Conflict Management Styles Used by Nurse Managers in the Sultanate of Oman

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Abstract

The purpose of this study was to explore the conflict management styles used by nurse managers in the Sultanate of Oman. Statistically significant differences related to demographic variables, including age, gender, nationality and educational level were examined, as well as years of experience as registered nurse or nurse manager and years in the current post. An approach combining quantitative and qualitative methods was employed to obtain a more precise and complete view of conflict management styles used by nurse managers from different levels, nationalities and genders with different nursing qualifications working in the same environment.

A total of 271 nurse managers participated in the quantitative part. They completed a form adapted from ROCI II (Rahim,1983). Three focus group interviews were conducted in three hospitals involving twenty nurse managers at first and middle levels from different nationalities. Percentage, means, standard deviations and non-parametric tests were used to analyse the quantitative data.

The results of this study indicate that nurse managers use different styles of conflict management, although there were differences in the choice of styles according to gender, nationality, nursing education, nursing management level and marital status. In addition to the five styles, the outcomes of the focus group interview discussions showed that nurse managers manage conflict by reporting it to a higher authority in order to avoid confrontation. The discussions provide explanations for the choice of styles used by nurse managers. The results show that the nurse managers' styles depend on the other party's position and gender; the majority of the participants agreed that age, years of experience, gender and nursing education played a role in conflict management style.

This study has implications for nurse managers, health policy makers, nursing educators and human resource departments in the nursing profession.

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Dedication

To my father

He constantly encouraged me to complete my PhD

But before I could finish it he died

This is dedicated to him

Never will I forget you or your words to me

I Love You Dad

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Chapter One: Introduction

1.1. Introduction

In this thesis the conflict management styles used by nurse managers in the Sultanate of Oman (one of the Arab countries) are explored. The researcher's interest in this topic a rose primarily from his daily involvement with the provision of continuing education for the nurse managers. It was recognised that nurse managers face conflict daily, but are not well prepared to deal with it effectively. Managing conflict successfully is one of the challenges nurse managers frequently face (Forte, 1997), and it therefore plays a crucial role in the effective functioning of nursing organisations, and consequently in maintaining the excellence of nursing care (Vivar, 2006).

This chapter provides an overview of the significance of the study. It also introduces the conceptual framework and the purpose of the study, presents research questions and research hypotheses, provides operational definitions for the terms used in this study, outlines the thesis and the limitations of the study and presents an overview of Oman, its geographic features, the population, the health system and the nursing workforce. This review will enhance understanding of the significance of the problem which is the focus of this study.

1.2 Significance of the study

The present study is significant for several reasons. Few studies have examined conflict management styles in the field of nursing. In Oman in particular, and in Arab countries in general, no studies were found regarding conflict management styles used by nurse managers. Most studies recently have been carried out in western contexts, so it is to be expected that different results might be obtained in different cultures such as that of Oman. This study offers an important contribution in this respect: it will provide groundwork for other research and studies in relation to this topic. In addition, conflict and its management are important variables in each organisation regarding attraction to the job, job satisfaction, staff retention and the mental health of the individuals concerned. The styles used by nurse managers to manage conflict are important to their performance, to the control of their teams and to the improvement

of the quality of patient care. The study also affords the opportunity to compare findings related to conflict management styles used by Omani and non-Omani nurse managers.

The ability to manage conflict constructively is probably one of the most important skills that an individual can possess, yet there are few opportunities to learn and practice these skills. Knowledge about one's conflict management style may help the administrator diagnose possible problems regarding the overuse or under use of various methods, since one single approach is not effective for managing every type of conflict.

The ability to creatively manage internal conflict in organisations is becoming a standard requirement for nurse managers (Hendel et al, 2005), and with the current shortage of registered nurses, effective conflict management plays an important role in staff retention (Woodtili, 1987). When nurse managers have knowledge of, and the ability to assess, their own conflict management styles, they possess a greater sense of control over their responses in conflict situations. Equally importantly, nurse managers with this knowledge can assess clients' conflict styles and recommend appropriate interventions. Nurse managers who understand conflict and its management will be better equipped to utilize conflict management strategies for themselves and to provide therapeutic interventions to their clients in problem-solving activities.

1.3 Statement of the problem

Nurses and physicians comprise the largest segment of health care providers and are daily confronted with complex problems involving conflicts among staff, but they find difficulty in solving these conflicts due to lack of experience and knowledge (Cavanagh, 1991). The maturity of the individuals involved in these conflicts has been found to be one of the main factors affecting the choice of the most appropriate style of conflict management (Marquis and Huston, 1996). Knowledge about conflict management is required by all nurses, especially nurse managers, because all managers within health care act under constant pressure from board levels. Conflict is inevitable in everyday social, organisational, and professional nursing life, and nurse managers deal with internal and external conflict daily (Cavanagh, 1991).

Selection of nurse managers is frequently determined by seniority or excellence in clinical practice, and nurse managers have been promoted without having had the opportunity to acquire the appropriate managerial experience. In Oman, the shortage of nurse managers due to the rapid turnover and the nationalisation process (replacing non-citizen nurses with Omani ones) has led to upgrading nurses from the position of staff nurse to nurse manager without preparation or training. Beaman (1986) mentions the importance of preparing nurse managers to be able to skilfully and competently handle people and operations as well as money and information. Hendel, Fish and Galon (2005) go even further, recommending that preparation in conflict management should start from undergraduate education.

Because nurse managers deal with internal and external conflict on a regular basis, they must understand the importance of, and become skilled in, conflict management. Nurse managers are responsible for not only managing conflict created by changes external to the organisation but also managing intraorganisational interpersonal conflict, this conflict may occur between two individuals, within small groups and work teams, or between groups (De Dreu and Van de Vliert, 1997) such as physician-nurse, nurse-patient, nurse-nurse, and nurse-other personnel. In so doing, they control or influence the total climate of a patient care unit.

Nurse managers must therefore be skilful in managing conflict in order to achieve positive outcomes. Conflict is not an easy matter with which to contend, especially in a hospital, where many different personalities may be involved. The management of conflict tends to be even more complicated when the parties have different assumptions, rules and styles that reflect their unique personalities and cultural values. This requires the manager to have knowledge and skill in the application of conflict management styles. Conflict management is an administrative process that becomes an integral and essential aspect of organisational activity (Valentine, 1995). Ting-Toomey et al (1991) assert that it is often not the issue itself but the differences in conflict management styles that create the greatest tension in a conflict situation.

This research proposes to remedy some of the shortcomings of previous work regarding conflict management styles used by nurse managers. There is an absence of investigation or exploration in the existing literature regarding conflict management used by nurse managers in Arab countries. Nurse managers are involved in managing

the complex processes entailed in direct patient care. In fact, the conflict management styles of nurse managers can influence the quality of care delivered to patients. This study therefore utilises samples of nurse managers from different hospitals using a multi-method approach (triangulation) to gain a more comprehensive view of the conflict management styles used by nurse managers in the Sultanate of Oman. There has been no research done in Oman or other Arab countries which has examined the conflict management styles of nurse managers. The researcher expects the results to increase understanding of the behaviour of nurse managers and their ability to deal with conflict, an understanding which will lead to the acquisition of additional and necessary knowledge to supplement existing nursing theories, and to help nursing scholars in their studies regarding nursing and nursing management.

1.4 Conceptual framework

The model that guided the research was a synthesis of the models of Pondy (1967), Wall and Callister (1995) and Rahim (1983), who described the nature of conflict management styles in terms of five predominant types. The five styles are based on a two-dimensional model (Figure 2.2) that compares the degree to which individuals satisfy their own concerns and needs (assertiveness) with the degree to which individuals attempt to satisfy the concerns of others (co-operation) (Blake and Mouton,1964; Thomas, 1976; and Rahim,1983). Superimposed on this two-dimensional model are the five possible orientations representing the action an individual might take in satisfying his own needs as compared to those of another. These five orientations represent the conflict management styles which will be described later, namely accommodation, avoidance, collaboration, competition and compromise.

1.5 Aims and objectives

The aim of this study is to explore the styles of conflict management used by nurse managers in the Sultanate of Oman. Statistically significant differences will be explored with respect to demographic variables, specifically age, gender, educational level and years of experience.

The objectives of this study are:

1- to identify the extent of the gap in the knowledge, of the nurse managers in Sultanate of Oman concerning conflict management in nursing

2- to explore and compare the conflict management styles used by the nurse managers in Sultanate of Oman

3- to identify the roles of culture, gender and other variables, related to the nurse managers working in Sultanate of Oman, in conflict management

4- to contribute to the field of knowledge in this area of work

1.6 Research Questions

The researcher approached this study with one general question in mind: What styles of conflict management do nurse managers in the Sultanate of Oman use? The study will focus on the following subsets of questions:

1. What is the relationship between age and conflict management styles?
2. What is the relationship between gender and conflict management styles?
3. What is the relationship between educational level and conflict management styles?
4. What is the relationship between the number of years of experience as registered nurse, nurse manager and manager in this post and conflict management styles?
5. What is the relationship between nurse managers' marital status and conflict management styles?
6. What is the relationship between the nationality of the participant and conflict management styles?
7. What is the relationship between management levels within nursing departments and conflict management styles?

1.7 Research Hypotheses

It was anticipated that the data from this study would find that nurse managers preferred the collaborating conflict management style. But to answer the other research questions and find out the relationship between these factors and conflict management styles, the following research hypotheses have been formulated:

Hypothesis one: there is no significant relationship between age and conflict management styles.

Hypothesis two: there is no significant relationship between the years of experience and conflict management styles.

Hypothesis three: there are no differences between male and female managers in conflict management styles.

Hypothesis four: there is no significant relationship between nationality and conflict management styles.

Hypothesis five: there is no significant relationship between educational preparation for nurse managers and conflict management styles.

Hypothesis six: there is no significant relationship between management level and conflict management styles.

Hypothesis seven, there is no significant relationship between marital status and conflict management styles.

1.8 Definition of Terms

For the purpose of this study, the following definitions are adopted:

"Conflict" refers to "an expressed struggle between at least two interdependent parties who perceive incompatible goals, scarce rewards, and interference with the other party in achieving their goals" (Hocker and Wilmot, 1991, p.23)

"Conflict Management Styles" refers to the use of one of the five styles described by Rahim (1983) collaboration, compromise, accommodation, competition or avoidance , to manage conflict, as measured by the Rahim Organisation Conflict Inventory II (ROCI II). Conflict management styles are patterned responses to a conflict and are usually assessed in research by having an individual disclose what he or she normaly does in a conflict situation. Conflict management styles can be viewed as a function of the interaction of two variables: the degree of concern an individual shows for relationships with others, and the degree of concern the individual shows for achieving personal goals (Rahim 1983). According to Rahim (1983) styles of conflict management include:

a) Collaboration (integrating) – reflects a high concern for both one's own goals and those of others. This style explores and examines each conflict party's

interests to find a solution that is acceptable and beneficial to both parties. Problem solving communication, openness, and exchanges of relevant information presumably lead to creative solutions.

b) Compromise – reflects a moderate concern for one's own goals and those of others. Using this style, each party is willing to give up some resources and seek a middle-ground solution. In short, both parties give in order to gain.

c) Accommodation (obliging) – reflects a low concern for one's own goals and a high concern for those of others. This style involves an attempt to minimise differences and conflict by surrendering to the other party's wishes.

d) Competition (dominating) – reflects a high concern for one's own goals and a low concern for those of others. This style is evident in attempts to use one's power to secure his or her position or to achieve an objective by ignoring the other party's needs. It typically entails a win-lose orientation.

e) Avoidance – reflects a low concern for both one owns goals and those of others. It is a passive strategy characterised by attempts to withdraw from a conflict situation, withhold complaints, and refrain from an open discussion of conflict issues.

"Educational level" refers to the highest level of formal education that a given nurse manager has achieved, such as diploma, bachelor and master degree in nursing.

"Level of nursing management" Registered nurse employed in the field of nursing, who works at present as nurse manager in the first, middle and top levels of nursing management at one of the regional referral hospitals, and is employed by the Ministry of Health in the following areas of responsibility:

a. **First-line nurse manager-** the person responsible for a single clinical area or department who has primary responsibility for staff performance. The title varies depending on the organisational structure, but may include ward in-charge, ward nurse and acting ward in-charge. This person reports to a middle manager or to the head of a nursing department.

b. **Middle-level nurse manager** – the person who has a responsibility for two or more clinical areas or departments. The title varies according to organisational structure, but includes nursing supervisors, unit heads and assistant heads of

nursing departments. This person reports to the head of the nursing department or his/her assistant.

c. **Top-level nurse manager** – the head of the nursing department, responsible for the entire department of nursing. The title varies depending on the organisational structure. This person reports directly to the chief executive officer or medical superintendent.

"Years of nursing experience" refers to the cumulative number of years a staff member has spent as a nurse in different levels and different institutions since they registered as a nurse in any nursing council throughout the world.

"Years of nursing management experience" refers to the cumulative number of years spent in a position or positions involving decision-making related to meeting the goals of the department of nursing.

1.9 Oman: geographic and demographic features

The aim of this section is to give the reader an overview of Oman, concentrating on location, geography, demographics and health problems. The reader will then have some knowledge about the environment surrounding the participants in this study.

The Sultanate of Oman is located in the south-eastern corner of the Arabian Peninsula. Its coastline extends 1,700 kilometres, from the Strait of Hormuz in the North to the borders of the Republic of Yemen. The Sultanate overlooks three seas: the Arabian Gulf, the Gulf of Oman, and the Arabian Sea. It borders the Kingdom of Saudi Arabia and United Arab Emirates in the west, the Republic of Yemen in the South, the Strait of Hormuz in the North and the Arabian Sea in the East. The Sultanate is composed of varying topographic areas consisting of plains, wadis (dry riverbeds), and mountains (Ministry of Health, 2004).

The following table describes the demographical criteria of the population of Oman.

Table 1.1 Demographical statistics (Ministry of Health, 2006)

Indicator	Value
Total area	309.5 thousand km^2
Total Population	2,508,837
Nationality	76.1 per cent citizens and 23.9 per cent non-citizens
Population density	7.6 persons per km^2
Population below 5 years of age	11.9 per cent
Population below 15 years of age	38.9 per cent
Population 60 years of age and over	3.5 per cent
Life expectancy	74.28 years (total population) 73.16 Male 75.42 Female
Total fertility rate	3.14
Child mortality (deaths of children under 5 years of age per 1000)	12
Adult mortality (between 15-59 per 1000)	163 for males 91 for females

The results of the 2003 census (Ministry of National Economy, 2004) show there are 128 males per 100 females in the population as a whole and 102 male for every 100 female for Omani nationals. Ethnically, the population is predominantly Arab, with significant minorities of Indians, Pakistanis and East Africans, mostly found in the principal ports. In terms of religion, the majority of the population is Ibadhi Muslim; Sunni Muslims form the other major religious group. Arabic is the official language but English is widely used as second language.

Agriculture and fishing are the traditional ways of life in Oman and 40 per cent of the labour force is in agriculture and trade. Oil is considered the first source of income in Oman (Ministry of National Economy, 2004).

Administratively the Sultanate of Oman is divided into five regions and three governorates with 59 Wilayats, or small governorates. The regions are Ad Dakhliyah, Ash Sharqiyah, Al Batinah, Ad Dhahirah and Al Wusta, and the governorates are Muscat, Dhofar and Musandam. The regions of Ash Sharqiyah and Al Batinah have

each been subdivided into two for the purposes of health administration, giving ten health regions.

Figure 1.1: Map of the Sultanate of Oman

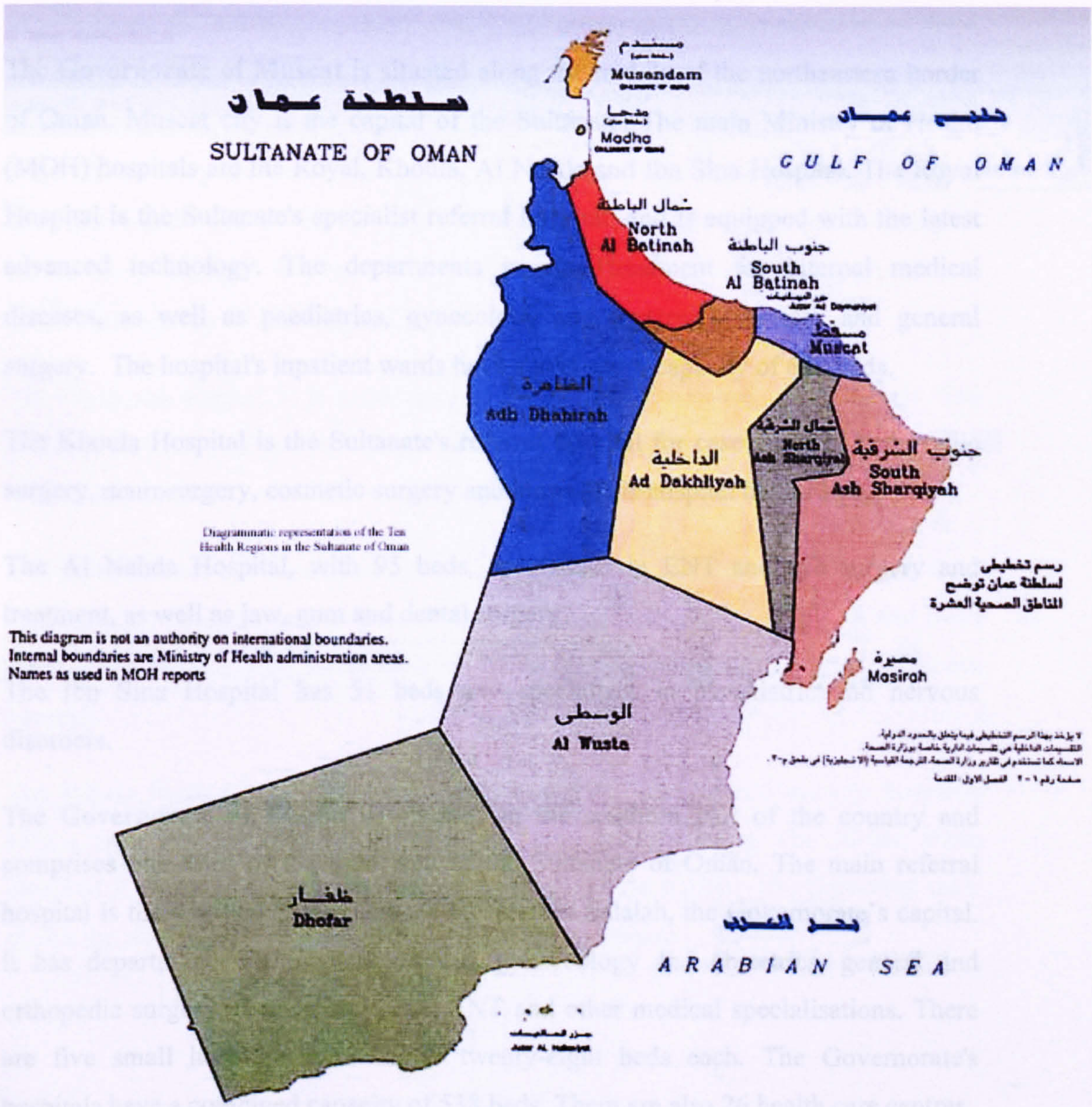

Figure 1.2: Map of the Sultanate of Oman showing the ten Health Regions (MOH, 2003)

The **Governorate of Muscat** is situated along the middle of the northeastern border of Oman. Muscat city is the capital of the Sultanate. The main Ministry of Health (MOH) hospitals are the Royal, Khoula, Al Nahda and Ibn Sina Hospital. The Royal Hospital is the Sultanate's specialist referral hospital, and is equipped with the latest advanced technology. The departments provide treatment for internal medical diseases, as well as paediatrics, gynecology and maternity services and general surgery. The hospital's inpatient wards have a maximum capacity of 632 beds.

The Khoula Hospital is the Sultanate's referral hospital for cases such as orthopedic surgery, neurosurgery, cosmetic surgery and burns. This hospital has 428 beds.

The Al Nahda Hospital, with 95 beds, specializes in ENT and eye surgery and treatment, as well as jaw, gum and dental surgery.

The Ibn Sina Hospital has 51 beds and specialises in psychiatric and nervous disorders.

The **Governorate of Dhofar** is situated in the southern part of the country and comprises one third of the total area of the Sultanate of Oman. The main referral hospital is the 450-bed Sultan Qaboos Hospital in Salalah, the Governorate's capital. It has departments for medical disease, gynaecology and obstetrics, general and orthopedic surgery, dermatology, eye, ENT and other medical specialisations. There are five small hospitals with six to twenty-eight beds each. The Governorate's hospitals have a combined capacity of 538 beds. There are also 26 health care centres.

There are six hospitals in the **Dakhliyah region**, situated in the central part of Oman. The region's referral hospital is the 301-bed Nizwa Hospital. The region's hospitals have a combined total of 547 beds. Other services include the Nizwa Polyclinic and thirteen health centres.

The **Sharqiyah Region** is situated in the eastern part of Oman, and is divided into North and South Sharqiyah. The 191-bed Ibra Hospital is the referral hospital for North Sharqiyah, which also has nine health centres. The 243-bed Sur Hospital is the regional hospital for South Sharqiyah, which is also served by the Sur Polyclinic and twelve health centres. The number of beds for the region as a whole is 724.

The Batinah Region is in northern Oman and is one of the most densely populated areas in the country. The region has ten hospitals and again is divided into North and South Batinah. The 363-bed Sohar Hospital is the regional referral hospital for the north Batinah Region, where there is also the Sohar Polyclinic, three other polyclinics and eight health centres. The 235-bed Rustaq Hospital is the regional referral hospital for the South Batinah Region, which has two polyclinics. The Batinah region has a combined capacity of 761 hospital beds.

The **Dhahirah Region** is in northwestern Oman. The region has five hospitals. The 240-bed Ibri Hospital is the referral hospital for the region, which has a combined total of 407 hospital beds. There are also thirteen health centres.

The **Governorate of Musandam** is in the northern part of the Sultanate. It has three hospitals; the total number of hospital beds in the governorate is 156 beds and three health centers. The 100-bed Khasab Hospital is the Governorate's regional referral hospital.

The **Wusta Region** is situated in the middle of the Sultanate, and has two hospitals with a combined capacity of 52 beds and seven health centres. The 24-bed Hima Hospital is the regional referral hospital for the Wusta region. The following table shows the distribution of population by governorate/ region.

Table 1.2: Distribution of Population by Governorate/Region (Ministry of National Economic, 2004)

Governorate/ Region	Population	Regional population as a percentage of total population	Population density (persons/km^2)	Total area/km^2	Numbers of referral hospitals
Muscat	632,073	27%	162.1	3,900	4
Al Batinah	653,505	28%	52.3	12,500	2
Musandam	28,378	1.2%	15.8	1,800	1
Adh Dhahirah	207,015	8.8%	4.7	44,000	1
Adh Dakhliyah	267,140	11.4%	8.4	31,900	1
Ash Sharqiyah	313,761	13.4%	8.6	36,400	2
Al Wusta	22,983	1%	.3	79,700	1
Dhofar	215,960	9.2%	2.2	99,300	1
Total	**2,340,815**	**100%**	**7.6**	**309,500**	**13**

1.10 Development of health services and health care in Oman

The Ministry of Health in Oman was established in August 1970. Since then it was able to build from scratch a modern national system that offers all Omani citizens universal accessible health services free of charge.

The country has made important achievements in health over a short period of time. Health indicators have shown a remarkable decline in mortality rates and an increase in life expectancy for the Omani people. The following table shows the development in health services in Oman.

Table 1.3: Health services indicators in the Sultanate of Oman (MOH, 2006)

Indicators	1985	1995	2005
Number of hospitals (total)	44	53	58
Numbers of hospital beds	3,040	4,564	5,270
Bed/Doctor ratio	3.1	1.7	1.3
Bed/Nurse ratio	1.4	0.7	0.6
Number of health centres, Clinics (Governmental)	130	163	184
Number of private clinics	255	471	713

The health taskforce indictors also show a dramatic improvement over the last twenty years, as summarised in the following table.

Table 1.4: Health human resources indicators in Sultanate of Oman (MOH, 2006).

Indicators	1985	1995	2005
Total number of doctors	958	2,258	4,182
Doctors (per10,000 of total population)	6.9	11.8	16.7
Doctors (General Practitioner) (per 10,000 of total population)	5.4	8.2	10.9
Doctors (specialists) (per 10,000 of total population)	1.6	3.7	5.7
Total number of nurses	2,288	6,036	9.277
Nurses (per 10,000 of total population)	16.6	28.9	37.0
Total number of dentists	53	143	448
Dentists (per10,000 of total population)	0.4	0.7	1.8
Total number of pharmacists	193	356	753
Pharmacists (per 10,000 of total population)	1.4	1.7	3

Besides this expansion of health services during the last 35 years, the integration of curative, preventive and promotive services was emphasised. Public health units in peripheries were amalgamated with nearby hospitals and health centres. The aim was to provide the people of the Oman with full comprehensive health care. A special health program for strengthening primary health care was developed to identify and manage the challenges in implementing its strategies. Wilayat health teams were established, the wilayat being the smallest administrative unit, and therefore of most immediate concern to a community. This was accompanied by the establishment of 140 health centres.

The expansion in health services has resulted in improvements in the health of the community, reflected in a decline in preventable diseases and in infant and child morbidity and mortality (table 1-5).

The expanded program of immunisation, established in 1981, resulted in no cases of diphtheria being reported since 1991 and no poliomyelitis since 1993. Only one case of tetanus neonatorum has been reported since 1991. The number of measles cases declined dramatically to only nine, and rubella to only 5, during 1999. Immunisation

against Hepatitis B covered 99.9 per cent of the population in 1999. The following tables show the achievements in health status.

Table 1.5: Mortality indicators (MOH, 2006)

Indicator	1985	1995	2005
Crude death rate per 1000	9.9	6.1	2.53
Infant mortality rate per 1000 live births	45	20	10.28
Under 5 mortality rate	52	27	11.05
Still birth rate per 1000 births	16.4	11.8	9.1
Maternal mortality rate (per 100,000 live births	na	22	15.4

Table 1.6: Health care indicators (MOH, 2006)

Indicators	1985	1995	2005
Immunisation in children one year of age against:			
BCG	93%	96.3%	99%
OPV3	60%	99%	99.9%
DPT3	60%	99%	98.6%
Measles	65%	97.5%	98.86%
Hepatitis B	n.a	99%	99.9%
Mean number of ante-natal visits	4.5	7.1	8.6
Post-natal visits/first antenatal visits ratio	.12	1.2	1.29
Mean number of outpatient visits(per person per year)	5.1	5.8	4.2
Bed occupancy rate % per cent	86	69	52.8
Mean length of hospital stay (day)	4.8	4.4	3

After the success of primary health care programs, programs to control the non-communicable diseases like diabetes mellitus, cardiovascular, and obesity were started. Now cardiac arrest, road traffic accidents and cancer are the main causes of mortality and morbidity in Oman.

The next table shows the morbidity rate in Oman and the main causes of morbidity in hospitals.

Table 1.7: MOH Hospitals inpatients morbidity according to age groups and disease category during 2005 (MOH, 2006)

ICD 10 Group No.	Disease Conditions	Total	> 60 years	45 - 60 Years	15-44 years	5 - 14 years	1 - 4 years	29 days -<1 year	7 - 28 days	< 7 days
1	Infectious and Parasitic Diseases	**12,902**	1,046	758	1,910	1,660	4,796	2,669	48	15
2	Neoplasm	**3,382**	894	872	1,249	227	106	28	0	6
3	Disease of Blood & Blood Forming Organs	**5,223**	275	192	2,224	1,558	810	138	12	14
4	Disorders of the Endocrine, Nutritional, Metabolic & Immunity	**5,600**	1,716	1,663	1,197	333	486	151	33	21
5	Mental & Behavioural Disorders	**1,588**	156	228	1,113	65	18	5	2	1
6	Diseases of the Nervous System	**2,949**	409	390	1,097	595	302	132	12	12
7	Diseases of the Eye & Adnexa	**3,693**	1,492	1,153	653	233	125	26	5	6
8	Diseases of the Ear & mastoid process	**1,196**	61	101	526	258	183	66	0	1
9	Diseases of the Circulatory System	**15,024**	6,938	5,108	2,525	265	98	81	5	4

ICD 10 Group No.	Disease Conditions	Total	> 60 years	45 - 60 Years	15-44 years	5 - 14 years	1 - 4 years	29 days -<1 year	7 - 28 days	< 7 days
10	Diseases of the Respiratory System	**29,191**	2,476	2,243	4,827	5,281	8,972	5,209	161	22
11	Diseases of the Digestive System	**13,244**	1,533	1,922	5,847	2,025	1,455	428	27	7
12	Diseases of the Skin & Subcutaneous Tissue	**3,331**	317	405	1,458	525	457	153	13	3
13	Diseases of the Musculoskeletal System & Connective Tissue	**4,153**	452	711	2,107	576	249	54	4	0
14	Diseases of the Genitourinary System	**9,466**	1,405	1,550	4,661	905	661	269	9	6
15	Pregnancy, Child Birth and the puerperium	**56,919**	0	386	56,525	8	0	0	0	0
16	Conditions Originating in the Perinatal Period	**5,001**	0	0	0	0	10	290	824	3,877
17	Congenital Anomalies, deformations & Chromosomal abnormalities	**2,654**	14	25	265	493	810	607	166	274
18	Symptoms,	**11,783**	1,430	1,215	4,352	1,908	1,851	882	88	57

ICD 10 Group No.	Disease Conditions	Total	> 60 years	45 - 60 Years	15-44 years	5 - 14 years	1 - 4 years	29 days -<1 year	7 - 28 days	< 7 days
	Signs and Ill-Defined Conditions									
19	Injuries and Poisoning	**17,835**	1,337	1,835	8,540	3,509	2,138	458	6	12
21	Contact with Health Services for other reasons	**14,715**	1,264	1,676	6,754	1,460	1,273	1,238	147	903
	TOTAL	**219,849**	**23,215**	**22,433**	**107,830**	**21,884**	**24,800**	**12,884**	**1,562**	**5,241**

1.11 Health Care in Oman

The Ministry of Health is responsible for ensuring the availability of health care to the people of Oman. Health services in the Sultanate have developed tremendously over the past 30 years. The achievements of Oman in the development of its health services are outstanding. In 2000, the World Health Organization (WHO) hailed the country's excellent health achievements and placed it eighth in the world with regard to providing comprehensive health care. In an analysis of 191 countries worldwide, it was ranked first for health system efficiency and good utilisation of financial resources in health services (Ministry of Information, 2003).

In 1970, the MOH was responsible for providing most of the country's health services, and for the next ten years was solely responsible for the population's primary health care. Today it provides 87 per cent of the country's hospitals and hospital beds, as well as 90 per cent of both outpatient services and of inpatient services.

The MOH is the main provider of health care services in the Sultanate and has 80.5 per cent of the total health manpower (Ministry of Health 2004). Other Government health care providers include the Ministry of Defence, Royal Oman Police, Petroleum Development Oman and Sultan Qaboos University, but each of these are mainly for their employees and dependents. The University Hospital also provides both secondary and tertiary care for the general population. These non-MOH governmental health care providers are located in the Muscat region. Furthermore, there is a growing private health care industry that operates on a for-profit basis.

In 1970, there were only two hospitals with 12 beds and 9 clinics. By 2005, the MOH had 49 hospitals. The types of health institutions run by the MOH may broadly be described as:

Regional hospitals provide secondary and tertiary care to inhabitants of the health region in which they are located. They are usually built in the centres of health regions and are considered as referral hospitals for critical cases from other hospitals and health centers of their health regions. Regional hospitals of the Muscat Governorate act as national referral hospitals for critical cases from other regional hospitals. These Muscat hospitals are the Royal, Al-Nahda, Khoula and Ibn-Sina Hospitals.

Wilayat hospitals which provide both primary and secondary care to inhabitants of their own and nearby wilayats. These hospitals provide general medical, surgical, paediatric and normal delivery services. Patients needing advanced treatment are transferred to the regional hospitals.

Local hospitals which provide primary health care services to the inhabitants of nearby villages. In addition, they supply in-patient services to those patients who are in need of continuous medical care and/or observation. They are considered as primary health institutions.

Health centres and extended health centres provide primary health care to the people in the surrounding catchments areas. They are the first point of contact for the local population. There are now 4,542 hospital beds in these hospitals. (MOH, 2006)

Table 1.8: Geographical distribution of MOH Hospitals as of December 31, 2005 (MOH, 2006)

Governorate/ Region	Regional hospitals	Wilayat hospitals	Local hospitals	Total number of Hospitals	Number of hospital beds	Population per hospital bed
Muscat	4*	0	2	6	1.270	544
Dhofar	1	0	5	6	538	433
Ad Dakhliyah (Nizwa)	1	2	3	6	547	517
North Ash Sharqiyah (Ibra)	1	1	4	6	367	421
South Ash Sharqiyah (Sur)	1	1	2	4	420	422
North Al Batinah (Sohar)	1	1	3	5	460	943
South Al Batinah (Rustaq)	1	0	4	5	301	861
Adh Dhahirah (Ibri)	1	1	3	5	411	542
Musandam (Khasab)	1	0	2	3	156	195
Al Wusta (Hima)	1	0	2	3	72	340
Total	**13**	**6**	**30**	**49**	**4,542**	**552**

* Regional hospitals of Muscat Governorate act as national referral hospitals.

1.12 Nursing workforce

The rapid growth of health care services has created an increasing demand on the medical and nursing workforce. During the last three decades the proportion of nurses working in Oman to the general population has increased dramatically from 5.6 per 10,000 in 1975 to 31.5 per 10,000 in 2005 (MOH 2006). The nursing profession is the fastest growing health profession in the country. In 1975 there were just 450 nurses working in the MOH, but the number rose to 7,909 in 2005, 59 per cent of whom are Omani. (MOH, 2006).

Table 1.9: Nurses number in the Sultanate of Oman since 1975 (MOH, 2006)

Year	1975	1980	1985	1990	1995	2000	2001	2002	2005
Number of nurses	450	903	1,947	3,512	5,128	6,619	6,901	7,057	7,909

Table 1.10 :Distribution of MOH nurses according to the gender and percentage of Omani nurses

Total	Male	Female	Non Omani		Total	Omani		Total	per cent Omani
7,909	743	7166	Male	Female	3,229	Male	Female	4,680	59 per cent
			174	3,055		569	4,111		

The following table shows the total taskforce work at the MoH at the end of 2005 according to category

Table 1.11 Ministry of Health workforces by Category as of 31 December 2005 (MOH, 2006)

Categories / Code / No.	% Omani	Total			Non Omanis			Omani		
		Total	Female	Male	Total	Female	Male	Total	Female	Male
1 Health Administrators	95%	129	6	123	6	0	6	123	6	117
2 Doctors	27%	2,981	1,079	1,902	2,168	628	1,540	813	451	362
2.1 Medical Administrators	57%	47	15	32	20	1	19	27	14	13
2.2 Specialists/Consultants	23%	1,094	297	797	840	187	653	254	110	144
2.3 General Practitioners (GP	29%	1,840	767	1,073	1,308	440	868	532	327	205
3 Dentists	41%	168	68	100	99	34	65	69	34	35
4 Pharmacists	49%	154	78	76	79	19	60	75	59	16
5 Total Nurses	59%	7,909	7,166	743	3,229	3,055	174	4,680	4,111	569
6 Medical / Health Assistants	67%	6	0	6	2	0	2	4	0	4
7 Physiotherapists	64%	123	66	57	44	19	25	79	47	32
8 Sanitary Inspectors / Supervisors	86%	168	10	158	24	0	24	144	10	134
9 Radiographers	60%	401	159	242	162	17	145	239	142	97
10 Laboratory Technicians	52%	873	452	421	422	138	284	451	314	137
11 Asst.Pharmacists/Dispensers	69%	690	325	365	212	25	187	478	300	178
12 Medical Orderlies	99.9%	2,184	1,456	728	2	2	0	2,182	1,454	728
13 Other Para-Medical Staff	86%	831	395	436	117	22	95	714	373	341
14 Other Technical Staff	56%	179	26	153	79	1	78	100	25	75
14.1 Scientists/Engineers	43%	102	19	83	58	1	57	44	18	26
14.2 Technicians	73%	77	7	70	21	0	21	56	7	49
16 Teachers/Tutors	26%	268	192	76	199	145	54	69	47	22
Grand Total	66%	20,438	11,820	8,618	6,995	4,160	2,835	13,443	7,660	5,783

1.13 Summary

This chapter provided essential information to enhance understanding of the problem and its significance. This information consists of an introduction to the study and an overview of the Sultanate of Oman, a geographic, demographic and health services overview of the country with an emphasis on health, health problems and nursing taskforce development in Oman, an overview of the significance of the study, and the introduction of a conceptual framework. The research aim, questions and hypotheses were presented. In addition, operational definitions for the terms used in this study were given.

In the following chapter, a critical review of the relevant literature will be presented in order to provide an understanding of the problem and the previous research done to investigate it in various fields, with special emphasis on nursing and research conducted in Arab countries.

Chapter Two: Literature Review

Section One: Introduction

2.1.1 Introduction

This chapter provides an overview of the literature relating to the research questions, and commences with a description of how the literature was accessed and utilised for the purpose of this chapter. The literature review is vital to all steps of the research process. A literature review consists of a careful systematic and critical review of the most important scholarly activity on a particular topic (Krainovich- Miller 2002). The main goal of the literature review is to develop a strong knowledge base in order to carry out research and other scholarly educational and clinical practice activities. The literature review will draw together the knowledge on conflict and conflict management. It will also examine previous research in conflict management, and will review the effect of factors on conflict management styles.

The purpose of this chapter is to present a systematic and critical review of the important scholarly works concerning conflict, conflict management styles used by staff in all disciplines in general and by nurses and nurse managers in particular, and the factors affecting managers' use of such styles. The first section in this chapter presents the process of literature review. Section two analyses the concepts of conflict and conflict management. The third, fourth and fifth sections examine conflict and conflict management within the contexts, respectively, of nursing, culture and gender. Section six considers others factor in conflict management styles, and is followed by a conclusion.

2.1.2 The process of literature review

For the literature survey, international and national sources were accessed and material written in English and Arabic was selected for easy access and comprehensibility by the researcher. The study sample was drawn from the literature of disciplines that have studied conflict management, namely nursing, social sciences, health care, business, education, management and medicine from, 1960 to 2007. The

literature was reviewed using the computerised databases MEDLINE, Cumulative Index to Nursing and Allied Health Literature (CINAHL), Health Management Information Consortium (HMIC), Applied Social Sciences Index and Abstracts (ASSIA), British Nursing Index (BNI), Dissertation Abstract International, Proquest (ABI/inform, Dissertations, Psychology, Nursing) EBSCO, ZETCO and Emerald. Nursing and management material were also accessed using electronic search engines on the World Wide Web. Different journals and websites and direct or E-mail communication with scholars in conflict management in different countries were also used. Electronic and manual searches were conducted for archived material in Jordan University and Sultan Qaboos University in Oman. Searches in Arabic followed the same procedures as the English searches.

The initial search strategy was limited to the keywords 'conflict', 'conflict management', 'work environment', 'nurse managers', 'organisation management' and 'communication'. Also included were the following search terms as subject headings or keywords: conflict management, conflict management strategies, conflict resolution, conflict management styles, gender and conflict management, culture and conflict management. All of these were used as free text, after which other terms such as nurses, nurse managers and Middle East were progressively added.

The Proquest ABI/inform search resulted in 32 citations, EBSCO in 43, ASSIA 32, CINHAL, British Nursing Index and HMIC 117, INGENTA 11 and MEDLINE 196. According to the NHS centre for Review and Dissemination (2001), studies selected for review should be selected in unbiased way and the selection process should be documented detailing reason for inclusion and exclusion. Article abstract and summaries were reviewed to identify, which type of conflict, this paper investigate, population and the methodology used in the research. The exclusion criteria for the the studies included:

- Papers not relevant to the nurses or nursing subject
- Papers talk about political conflict or interpersonal conflict.
- Papers which did not have sufficient methodological quality to minimise biases. This was selected by applying criteria used by Polit, et al (2001) for

critiquing literature, such as methodology, population, sample size and outcome.

Using the structure literature review of the citation titles and available abstracts indicated considerable overlap. Some of the literature turned out not to be relevant to nursing or nurse managers; this applies specifically to articles with keywords found in the abstracts, but with conflict not being discussed in the body of the paper. After reviewing the citations the final titles were divided into groups according to the objective of the research and the subheadings of this chapter (for example, source of conflict, conflict management styles and nurse and conflict management).

Section Two: conflict and conflict management

2.2.1 Conflict: a concept analysis

Concept analysis is a means of clarifying a concept (Rodgers, 1989; Walker and Avant 2005). A variety of approaches can be used to perform a concept analysis. That of Walker and Avant considers the concept's definition, the use of conflict, its defining attributes, related concepts, antecedents, consequences and empirical referents. The rationale of this analysis is to provide a better understanding of the terms "conflict" and "conflict management", utilising the concept analysis method described by Walker and Avant (2005) and Wehr's conflict mapping guide described by Wilmot and Hocker (2001).

Conflict is a natural and pervasive phenomenon in human experience and it is seen as an important concept for nursing (Pondy, 1967; and De Dreu and Van de Vliert, 1997). Conflict is a part of people's lives in organisations as well as being a part of domestic life; indeed, it is inevitable, especially in a highly stressful environment (Shockley-Zalabak, 1981; Forte, 1997; and Jameson 1999). Conflict is not simply inevitable; it is the nature of complex organisations (Putnam, 1997). This applies to hospitals as much as to large and complex organisations in any competitive industry (Tengilimoglu and Kisa 2005). Conflict among nurses has been identified as a significant issue within nursing settings around the world. In Australia and Canada, recent studies have shown that the occurrence of conflict with nursing co-workers is

increasing (Farrell, 1997; Warner, 2001; and Hesketh et al., 2003), and in Japan, nurses experiencing conflict with other nurses have reported plans to leave their current nursing position (Lambert et al., 2004).

Gardner (1992) describes conflict in hospital nursing as pervasive due to the rapid pace of change and to turbulence in the current healthcare environment. Conflict is ever-present in organisations all over the world, playing a very significant role in them. According to Hurst and Keenan (2000), this is due to three reasons. Firstly, the 1990s was a very turbulent era, increasing the occurrence of conflict throughout organisations. Secondly, conflict cuts across every level of organisation, so that no one is left unaffected. Thirdly, organisations are conglomerates of individuals, groups, departments, special interests and divisions. Nurses are at the core of a myriad of interactions in which conflict is present. According to McElhaney (1996), nurse managers deal with internal and external conflict daily, and conflict is inevitable in everyday social, organisational and professional nursing life (Cavanagh, 1991). Conflict among nurses has been identified as a distinct and significant issue within healthcare settings around the world (Vivar, 2006). While the concept of conflict has been frequently discussed in nursing literature in recent years, the elements and processes of conflict remain unclear.

2.2.1.1 Definition and Uses of the Concept "Conflict"

The world "conflict" is defined in Webster's Third New International Dictionary (1986) as "a struggle to resist or overcome; contest of opposing forces or powers or a state or condition of opposition". The Concise Oxford Dictionary (1991) defines conflict as "serious disagreement or argument, a prolonged armed struggle or, an incompatibility between opinions, principles". The traditional view of conflict, promulgated in 1930s, maintained that conflict was destructive and dysfunctional with its competitive and detrimental aspects being the dominant theme. Conflict was therefore something to be avoided, suppressed or eliminated (Deutsch 1983). Different scholars in different fields have defined the term many times. Conflict is typically described as a dynamic process underlying a wide variety of organisational behaviour, and occurs whenever interdependent parties pursue incompatible goals, or incompatible relationships developed between two or more individuals in an organisation (Pondy, 1967 P. 299). These processes involve the interaction of two

interdependent parties who perceive incompatibility in goals, interests, values or ideas (Thomas, 1976; Rahim, 1986; and Rahim et al., 2000) Conflict occurs when one individual or group feels negatively affected by another (Thomas, 1976; Wall and Callister, 1995). Conflict occurs in all areas of life, and can be arranged into four broad categories; intrapersonal, interpersonal, organisational and international (Pondy, 1967; Marquis and Huston, 1996; and Hurst, 2000). The dominant model in this approach was Pondy's (1967) comprehensive one of organisational conflict, which conceptualised conflict as a dynamic process consisting of a series of conflict episodes. Each episode began with conditions having the potential for conflict, followed by perceptions, manifestations of behaviour and outcomes. While this model has never been directly tested, it is frequently cited in the literature. Thomas (1976) concludes that the word conflict has no single and precise definition. He views conflict as a process, one that includes the perceptions, emotions, behaviours and outcomes of the two parties. Specifically, conflict is a process that begins when one party perceives that the other has frustrated, or is about to frustrate, one of its concerns (p.990).

Many researchers have emphasised the negative outcomes of conflict, ranging from discomfort, misunderstanding, and disruption of relationships to the collapse of organisations (Ting- Toomey et a.,l 1991; Gardner 1992). Despite this early tendency to attribute largely dysfunctional effects to conflict, researchers began examining its positive dynamics and consequences. Conflict can be valuable to an organisation since it promotes innovative and creative problem solving, clarifies issues and allows underlying problems to rise to the surface (Kunaviktikul, 2000). Properly managed conflict couldindeed facilitate organisational growth (Valentine, 1995). Conflict was then seen as a natural phenomenon in teams and organisations, occurring as a result of malfunctioning people (Huber, 1996). It was depicted as having both positive and negative dynamics and consequences (Rahim and Bonoma, 1979). Understanding conflict is crucial in interpersonal and organisational contexts, where it ranks fifth among 65 important organisational issues (Putnam and Poole, 1992). The purpose of studying conflict in organisations is not to find ways to eliminate it altogether. With little or no conflict, an organisation can stagnate. At the other extreme, however, unmanageable conflict can damage organisational effectiveness. Rahim (1985) posits an inverted-U relationship between conflict and organisational effectiveness.

Organisational effectiveness is at its peak when conflict is at a moderate level. Conflict was most productive in a moderate amount and least productive at very low or high levels (Figure 2-1).

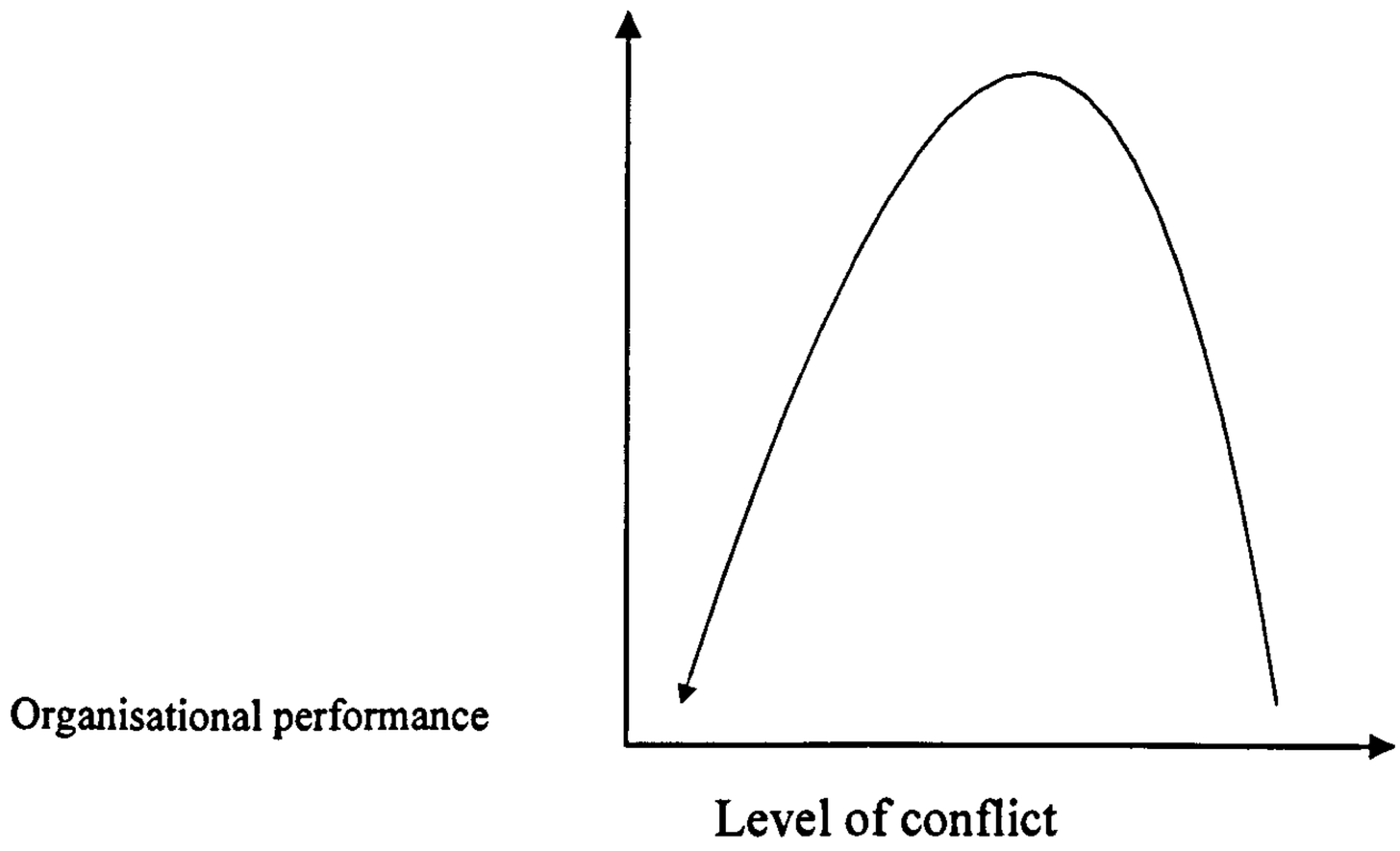

Figure 2.1: Relationship between conflict level and organisation performance (adapted from Rahim, 1985)

During the last two decades, researchers have examined when and under what circumstances conflict is detrimental and when it is beneficial. Conflict was no longer perceived as being good or bad but rather good and bad (Deutsch, 1983). It was shown to be a multidimensional construct, with both constructive and destructive effects depending on the type of conflict, the task at hand and how the conflict was managed (Jehn, 1994). This perspective encouraged elimination of the destructive effects of conflict while enhancing its constructive effects (Deutsch, 1983). This view continues to be widely accepted today; however, most researchers still focus on the negative effects.

nevertheless, conflict in nursing is frequently used with reference to the relationship between two sometimes adversarial groups, such as physicians and nurses, staff nurses and nurse managers or two different departments.

2.2.1.2 Defining attributes

The purpose of this section is to identify those characteristics without which conflict cannot be said to occur. A concept's attributes represent it as a real definition, making it possible to identify situations that are defined by the concept, as well as those that

can be characterised appropriately using the concept of interest (Rodgers, 1989). There are several important attributes of conflict within nurse managers work environments, including its stages and types. Organisational conflict may occur between two individuals, within small groups and work teams, or between groups (De Dreu and Van De Vliert, 1997).

Interpersonal conflict requires at least two people who have incompatible goals and want the same scarce resource. Admittedly, there is some divergence of opinion as to what the “other” is opposing. Thomas (1976) indicates the party's "concern" or "something cared about". Putnam and Poole (1987) cite the other's interference with the subject party's goods, aims and values. Donohue and Kolt (1992) refer to needs or interests, while Pruitt and Rubin (1986) discuss aspirations. Jameson (1999) refers to beliefs, values or goals. Peterson (1983) states that interference, or the perception of interference, is necessary to complete the conditions for conflict. Huber (1996) says that personal and organisational goals and values may diverge for reasons of general policy, resource allocation and the division of power, as well as the interaction of the individual needs with the organisation's needs and goals; conflict may also result from individuals’ attitudes, personalities, and personal behaviour (which refers to style, mannerisms and work habits). However, there is some divergence of opinion as to what is the `other`. In a recent study, nurses identified opposition or differences of opinion, priorities, roles, beliefs, perceptions, practices, authority and values during conflict situations (Warner, 2001).

2.2.1.3 Stages of conflict

Conflict occurs in a temporal sequence of stages or phases. Pondy (1967) described five stages of conflict:

- Latent, where conditions for conflict are present, but not recognised.
- Perceived, where an individual becomes logically and impersonally aware of a conflict. Sometimes it can be resolved at this stage before it is internalised or felt emotionally.

- Felt, where the conflict becomes personalised and the parties may feel anxious or even hostile; tensions build. It should be noted that it is possible to perceive conflict and not feel it; in this case no emotion is attached to the conflict, and the individual views it only as a problem to be solved. A person also can feel conflict but be unable to identify its cause.

- Manifest, also called overt, which is enacted through behaviours, and whose existence becomes obvious to uninvolved people.

- Conflict aftermath or the outcome of the conflict episode, where conflict is stopped by some method and new conditions are established. This aftermath may be more significant than the original conflict if that has not been handled constructively.

Thomas's (1992) model describes five stages of conflict: awareness, thoughts and emotions, intentions, behaviour, and outcomes. Awareness leads to a variety of thoughts and emotions about the episode and the development of potential responses. These responses, which are related to attempts to cope with the conflict situation, result in some type of observable behaviour. There is a reaction from the other person which results in an interaction that may be prolonged because each person's behaviour stimulates the other's response. As the interaction progresses, thoughts and feelings about the conflict issue may change, affecting behaviour accordingly. When the interaction stops, outcomes are produced.

2.2.1.4 Types of conflict

Several types of conflict have been identified; however, there is a lack of precision in the definition as well as considerable conceptual overlap (Dirks and Parks, 2003). According to Pondy (1967) conflict occurs in all areas of life and can be classified into three broad categories: intrapersonal, interpersonal and organisational.

- Intrapersonal conflict occurs within a person's psyche. It involves an internal struggle to clarify contradictory values or wants; for managers, conflict may result from multiple areas of responsibility to the organisation, subordinates, consumers, the profession and themselves, which are all associated with the management role.

Interpersonal conflict occurs between two or more people with differing values, goals and policies. For instance, the concepts of relationship, affective, and emotional conflict are difficult to distinguish, as are the concepts of task, debate, substantive, and cognitive conflict.

- Relationship (or affective / emotional) conflict exists when there are interpersonal incompatibilities, including personality clashes, tension, animosity and annoyance (Jehn, 1995). This type of conflict is usually very counterproductive, taking the focus away from issues that need to be resolved and shifting it to personal antagonism (Jehn, 1994; Friedman et al., 2000).

- Organisational conflict can be further subdivided into task and process conflict.

  - Task conflict (or cognitive) is an awareness of differences in viewpoints and opinions pertaining to a team task, including ideas and differences of opinion about the task (Jehn and Mannix, 2001). Task conflict can lead to dissatisfaction (Baron, 1988), but it can also have positive effects on productivity and team performance (Simons and Peterson, 2000).

  - Process conflict occurs when determining how the task should be accomplished, who is responsible for what, and how things should be delegated (Jehn and Mannix, 2001). While task conflict focuses on the content and goals of the work, process conflict focuses on how tasks would be accomplished (Jehn, 1995). The more diverse a team's values, the more likely they are to experience process conflict which, in turn, lowers team morale and decreases productivity (Jehn, 1995).

In summary, there are several important attributes of conflict including its stages and types. However, the common factor is the interaction between at least two people, where one or both perceive that they have opposing or incompatible interests to some degree.

2.2.1.5 Related concepts

The concept of conflict and collaboration are rarely seen as providing support for one another. It may be, however, that through collaboration the force generated in addresses the individual point of conflict. Henneman and Cohen (1995) mention that

collaboration represents one extreme of conflict resolution, in which the person is both assertive and cooperative. On the other extreme is avoidance, in which the person is unassertive and uncooperative. It is important to distinguish between conflict management styles of accommodation and compromise on the one hand and collaboration on the other, because accommodation and compromise may be used successfully in some settings. Nonetheless, conflict is not the opposite of cooperation but a mechanism that allows perceived benefits of cooperative work to come into play.

2.2.1.6 Antecedents

A significant number of personal and environmental factors influence whether or not conflict occurs. These antecedents apply to all parties involved, especially the primary ones. These factors can be distinguished as individual characteristics, personal factors and environmental or organisational factors. As the conflict process continues over time, the effects alter the original causes or generate new ones. These new causes, in turn, continue to swell the process if they are not resolved (Wall and Callister, 1995).

2.2.1.6.1 Individual characteristics

A number of factors related to personnel have been described as antecedents to conflict. These factors relate to individual as well as group characteristics. According to Volkema, Farquhar and Bergmann (1996) the personal factors influencing conflict are style/personality, gender, position/role and the conflict's history. Lemieux-Charles (1994) adds personal differences, lack of information, role incompatibility and environment stress. Demographic dissimilarity is also a factor that may influence conflict within teams. Jehn et al. (1997) found that gender differences increase relationship conflict, while differences in education increased task conflict. Conflicts between genders may occur because of the assumption that people of the same gender share the same values and find it easier to work and communicate with each other. The various educational levels may dictate how people think about and complete tasks (Ancona, 1990). Generational diversity also leads to conflict in nursing work environments, as each generation of nurses brings it is own set of values, beliefs, life experiences and attitudes to the workplace (Swearingen and Liberman, 2004). Previously, different generations were aligned based on seniority, with the oldest

members directing the youngest. Today, positional hierarchy is not related to age, and the most junior members of the workforce are frequently expected to contribute to decision making. Intergenerational interaction is dramatically increased, and unstated assumptions, perspective, and expectations can cause conflict. Transition from staff nurse to manager has been identified as a source of conflict and stress, as well as the lack of clarity concerning staff functions at this level (Oroviogoicoechea, 1996).

Communication is also an important antecedent to conflict, more specifically its style, whether verbal or non-verbal, or its absence (Warner 2001). Wall and Callister (1995) have pointed out that communication can be both the cause and the effect of conflict. Tengilimoglu and Kisa (2005) find that educational differences among the hospital staff are a major barrier to good communication and information flow between members of the group. Too often a person's words, facial expressions, body language or speech leads to attribution of intent, which results in conflict (Thomas and Pondy, 1977). The relationship between the parties is often shaped by events that have occurred in their past, and hence at some point along the continuum of conflict.

2.2.1.6.2 Environmental factors

Conflict can also be affected by environmental factors such as resources, structure, power and politics, climate and culture and norms (Folger and Poole, 1984; Rahim 1986). Gardner (1992) points out that organisational conflict occurs over policies and procedures in patient care. On the other hand, Porter-O'Grady (2004) mentions the differences in information, values and beliefs, experience, role, interests and goals as a source of conflict in organisations. Organisational values, which support collaboration and create conflict if the values is absent, include participation, support systems, autonomy, freedom of expression and interdependence (Lee, 2002). The strongest effect of the organisation is the creation of interdependence among team members (interdependence being the degree to which each needs the other to accomplish their work (Putnam and Poole, 1987). Teams with low levels of interdependence are less affected by conflict, while those with high levels of interdependence experience more (Jehan, 1994). In the healthcare environment, nurses' are interdependent with co-workers, managers, physicians and other health care professionals, departments, and units. Interdependence is a key aspect of the interdisciplinary team, and structures that create collaborative incentives and

conditions for joint success can prevent or reduce conflict (Thomas, 1992). For many years the power differential between nurses and doctors was been the main cause of conflict in nursing work environments. However, this is slowly changing, partly due to the rising level of nurses' education, and their ability to articulate what is important from a nursing perspective during interactions with physicians. Although conflict with doctors and patients still occurs, reports of conflict with managers and co-workers are gradually rising (Warner, 2001). Culture is another important element in the context of conflict, as it influences the parties' behaviours. Culture dictates attitudes and behaviour and influences the meaning people place on events and actions. Cultures vary according to identity groups such as ethnicity, gender, socio-economic class, and workplace. The interaction between two parties of different cultures can result in miscommunication and prolong conflict.

2.2.1.7 Consequences

Interpersonal conflict in organisations is non-hierarchical in nature. Many researchers emphasised on the negative outcomes of conflict, ranging from discomfort, misunderstanding and disruption of relationship to the collapse of organisations (Ting-Toomey et al., 1991; Gardner 1992). Sportsman (2005) states that conflict that continues over a period of time is typically destructive. Thomas's (1992) view is that conflict is an undesirable phenomenon that leads to negative effects, while Douglass (1996) emphasise that low levels of conflict may result in poor performance because individuals and group members apathetically tolerate each other's weaknesses and lack of performance, which builds up tension and stress. However, conflict is also constructive, as it can be the catalyst for new ideas, progress and positive change and growth (Rahim, 1986; White, 1998). Kunaviktikul (2000) also considers conflict as positive and valuable to the organization since it promotes innovative and creative problem-solving. Many conflicts are a mixture of competitive and cooperative impulses. Constructive conflicts appropriately balance the interest of both parties to maximise opportunities for mutual gain. The third group of researchers including Huber (1996) suggest that conflict itself is neutral and its outcome depends on source, level and –most importantly – how the people involved manage it, as well as the type of organisation and the occasion for the conflict.

Cox (2003) found that higher levels of intragroup conflict resulted in lower levels of nurses' job satisfaction, as did Gardner (1992) in a study of new graduate nurses. Conflict has also been linked to increased turnover and absenteeism, lower commitment and more grievances (Pondy, 1967). Forte (1997) points out that in clinical environments conflict among health care professionals is counterproductive to the patient. Nursing organisations are especially vulnerable to conflict due to the stress of the environment, the nature of the work and the diversity of interactions, workers and tasks (Kunaviktikul, 2000). Conflict, however, can also be valuable to an organisation since it promotes innovative and creative problem solving, clarifies issues, and allows underlying problems to rise to the surface, allowing them to be dealt with.

2.2.1.8 Empirical Referents

Empirical referents are classes or categories of actual phenomena that by their existence or presence demonstrate the occurrence of the concept itself (Walker and Avant, 2005). The complexity of conflict makes it difficult to define empirical referents. Conflict is dynamic. Even if parties have reached a settlement, aspects of the conflict's context will be in a state of flux. It is not possible to distinguish between critical attributes and empirical referents because these are identical in conflict situation.

2.2.2 Conflict Management Styles

Even though conflict appears to be a common phenomenon in human experience, each person deals with conflict situations differently. Conflict management has been identified, described, and categorised in a variety of ways by different authors. Some terms have been used interchangeably, and some terms have similar but not identical meanings. Vliert (1997) defines conflict management as what people who experience conflict intend to do as well as what they actually do. Jameson (1999) stated that the phrase "conflict management strategies" is used to describe any action taken by a disputant or a third party to manage or resolve a conflict. Effective conflict management is a vital skill that can be learned (Bartol et al., 2001). Management of conflict is extremely important for the effective functioning of organisations and for the personal, cultural, and social development of human beings. Constructive and creative conflict management is a real challenge and goal for any professional who is

genuinely interested in assisting others and the organisation as a whole in changing unfavourable conflict situations into positive, cooperative, and relatively peaceful directions. On the one hand, effective conflict management promotes motivation, enhances morale and promotes individual and organisational growth (Rahim, 1986).

Conflict management should broaden the understanding of problems, increase alternative resolutions and achieve a workable consensus and a genuine commitment to decision making. (Swansburg, 1990). Well-managed conflict can tap the creativity and problem-solving skills of colleagues, taking advantage of different gender, cultural, and role perspectives to create mutually beneficial solutions. Conflict poorly managed or consistently avoided reduces productivity, undermines trust and may spawn additional conflict (Siders, 1999).

According to Arrington (1987), management of conflict is a human relations concept long recognised in business and industry as a necessary component of the developmental process. Within organisational conflict literature, taxonomic models of interpersonal conflict styles have been delineated (Blake and Mouton, 1964; Kilmann and Thomas, 1977; and Rahim, 1983). Managing conflict is crucial in contributing to the effective functioning of nursing organisations, and consequently, to the excellence of nursing care (Vivar, 2006). An individual's cultural and family traditions, personality, and life experience all shape the ways in which he or she handles conflict (Campbell, 2003). Assumptions about conflict management styles made by researchers include that people develop patterned responses to conflict that make sense to them, that no one style is automatically better than another, and that people's styles undergo change in order to adapt to the demands of new situations (Hocker and Wilmot, 1991).

Conflict management is a function of high or low concern for self, combined with high or low concern for others (De Dreu et al., 2001). Because of a reliance on certain styles more than others, conflict handling approaches are viewed as relatively stable personal predilections (Ruble and Schneer, 1994 p.157). According to Ruble and Schneer individuals may adopt and enact other styles of conflict management,. Conflict well managed can tap the creativity and problem-solving skills of colleagues, taking advantage of different gender, cultural, and role perspectives to create mutually

beneficial solutions. Conflict poorly managed or consistently avoided reduces productivity, undermines trust and may spawn additional conflict (Siders, 1999).

Scholars have used many instruments to capture styles of conflict management in interpersonal and organisational contexts. These instruments reflect similar constructs, but many different models, which involve the creation of specific terms for them, are evident in the work of different researchers (e.g. Blake and Mouton, 1964; Rahim, 1983; and Thomas and Kilmann, 1974).

Blake and Mouton (1964) were the first to formalise a framework for managing organisational conflict. They developed a managerial grid composed of five basic styles of management that characterise an individual's likely behaviour in a conflict situation. The grid model consists of two measurable dimensions that have the greatest effect on the ways people work: concern for production and concern for people. Production is "whatever an organisation hires people to accomplish" (Blake and Mouton, 1985, p. 10). The orientations are:

- maximum concern for production combined with minimum concern for people (concentrates on maximising production by exercising power and authority)
- minimum concern for production is coupled with maximum concern for people (focuses on good feelings among colleagues and peers at the expense of achieving production)
- minimum concern for both production and people (does only the minimum to remain in the organisation)
- middle of the grid (intermediate concern for production and moderate concern for people, gives up half of one in order to obtain the other half)
- Integration of concerns for production and people.

Blake and Mouton's orientations have been reinterpreted and relabelled 'desire to satisfy one's own concern' and 'desire to satisfy others' concern' (Thomas, 1976) and 'concern for self' and 'concern for others' (Rahim, 1983). Individual conflict styles incorporate both dimensions to varying degrees. High concern for both self and others defines a 'collaborating' or 'integrating' style, while low concern for both self and

others defines an 'avoiding' style. High concern for self but low concern for others describes a 'competing' or 'dominating' style' while low concern for self but high concern for others describe an accommodating or obliging style (De Dreu et al., 2000).

Table 2.1: The different names for the five styles of conflict management.

Blake & Mouton (1964)	Thomas & Kilmann (1976)	Rahim (1983)
Forcing	Competing	Dominating
Withdrawing	Avoiding	Avoiding
Smoothing	Accommodating	Obliging
Sharing	Compromising	Compromising
Problem-solving	Collaborating	Integrating

Among the tools measuring the conflict management styles, the Rahim Organisation Conflict Inventory-II (ROCI-II) (Rahim, 1983) is one of the tools commonly used by researchers. According to Rahim (1985) interpersonal styles of conflict management are classified into five categories according to the relative extent to which a person is concerned about self and the amount to which the person is concern about others(figure 2.2). The five ways of handling conflict can be defined as avoiding, compromising, integrating, obliging, and dominating (Blake and mouton, 1964; Thomas and Kilmann, 1976; Rahim, 1983)

Avoiding results from low concern for self and others, which involves reducing the importance of the issues, and attempting to suppress thought about issues (Keenan, 1998). Avoiding simply refuses to address the conflict; it is an unassertive and uncooperative response. This approach is appropriate when the other party is more powerful (McElhaney, 1996). One possible explanation for the frequent use of this mode may be related to the sense of powerlessness associated with staff nurses and nurse managers' roles (Valentine, 2001). Valentine (1995) suggests that frequent use of avoidance is related to nurses' natural orientation towards self-sacrifice. Marriner (1995) maintains that avoiding produces unsuccessful results, but Robbins (1978) and Rahim (1986) find that it is a very effective short-term way to forestall a conflict situation. However, when avoidance is prolonged it may become dysfunctional, as it prevents recognition that a problem exists. Vivar (2006) indicates that the nurses in

the ward use avoidance as a primary strategy to manage conflict because they have three central concerns: they still behave according to the historical model of doctor dominance and nurse deference they have little time to discuss problems, as they are usually busy; and nurse managers have little knowledge of conflict management, as the role of leadership is a new type of challenge in nursing that needs greater study and practice.

Compromising results from moderate concern both for oneself and others. It involves intermediate levels of both assertiveness and cooperation. This approach focuses on quick, mutually agreeable decisions that partially satisfy both parties (Rahim, 1983). Compromising emerges when there is negotiation and interchange. Each person gains something but gives up something else in the process. Vliert (1997) sees compromising as a distinct strategy that involves the matching of others' concessions, making conditional promises and threats and an active search for a middle ground. Valentine (2001) points out that the frequent use of compromising indicates a focus mainly on the practical aspects of care. Larger issues such as principles, values, long-term goals or the organisation's wellbeing are not considered.

Integrating (Collaborating) involves one party working with the other to find a solution that satisfies both the parties. it confronts issues and arises from high concern for self and others. Collaboration is both assertive and cooperative, and involves an attempt to work with the other person to find a solution that fully satisfies the concerns of both the parties. This approach leads to mutually satisfying decision-making (Marriner, 1982). It involves an exchange of information about priorities and preferences, shows insights, and makes trade-offs between important and unimportant issues which mean each person or group tackles the problem with equal consideration. According to Vivar (2006) this approach is certainly the one that requires the most time in order to resolve the conflict, but it provides the most meaningful results because it encourages honest communication, incorporates others' opinions and ideas, does not seek concessions and leads to trust and amiability, (Chusmir and Mills, 1989).

Obliging (Accommodating) comes from low concern for oneself and high concern for others, which is orientated towards accepting and incorporating the other party's will. It involves unilateral concessions, unconditional promises and offers of help.

Accommodating is characterised by cooperative but unassertive behaviour. The accommodating individual exhibits self-sacrificial behaviour by neglecting his or her own concerns to satisfy those of the other person. Accommodation promotes harmony and gains credits that can be used at a later date (Marriner, 1982; McElhaney, 1996). Accommodation can at times appear relevant, as it encourages people to express themselves, resulting in an agreeable relationship between both parties (Skjorshammer, 2001). Valentine (2001) points out that infrequent use of accommodation indicates difficulty in relinquishing issues, in recognising legitimate exceptions to rules, in forming good intentions or in admitting that one is in the wrong. Low self-esteem and perceived powerlessness among nurses may make it difficult to waive issues, make exceptions, be charitable or admit to being at fault.

Dominating (Forcing) focuses on imposing one's will on others and involves threats and bluffs, persuasive arguments and positional commitment. Competing is an aggressive, uncompromising approach to conflict that is power-driven. The individual pursues his or her own personal goals without regard for others. This approach is appropriate to use when a quick or unpopular decision must be made or to protect oneself or someone else from an aggressor (McElhaney, 1996; Vivar, 2006) or in an emergency situation. Valentine (2001) points out that infrequent use of competing indicates difficulties in taking a firm stand on issues. It may mean lack of awareness of power and skills or discomfort in using them.

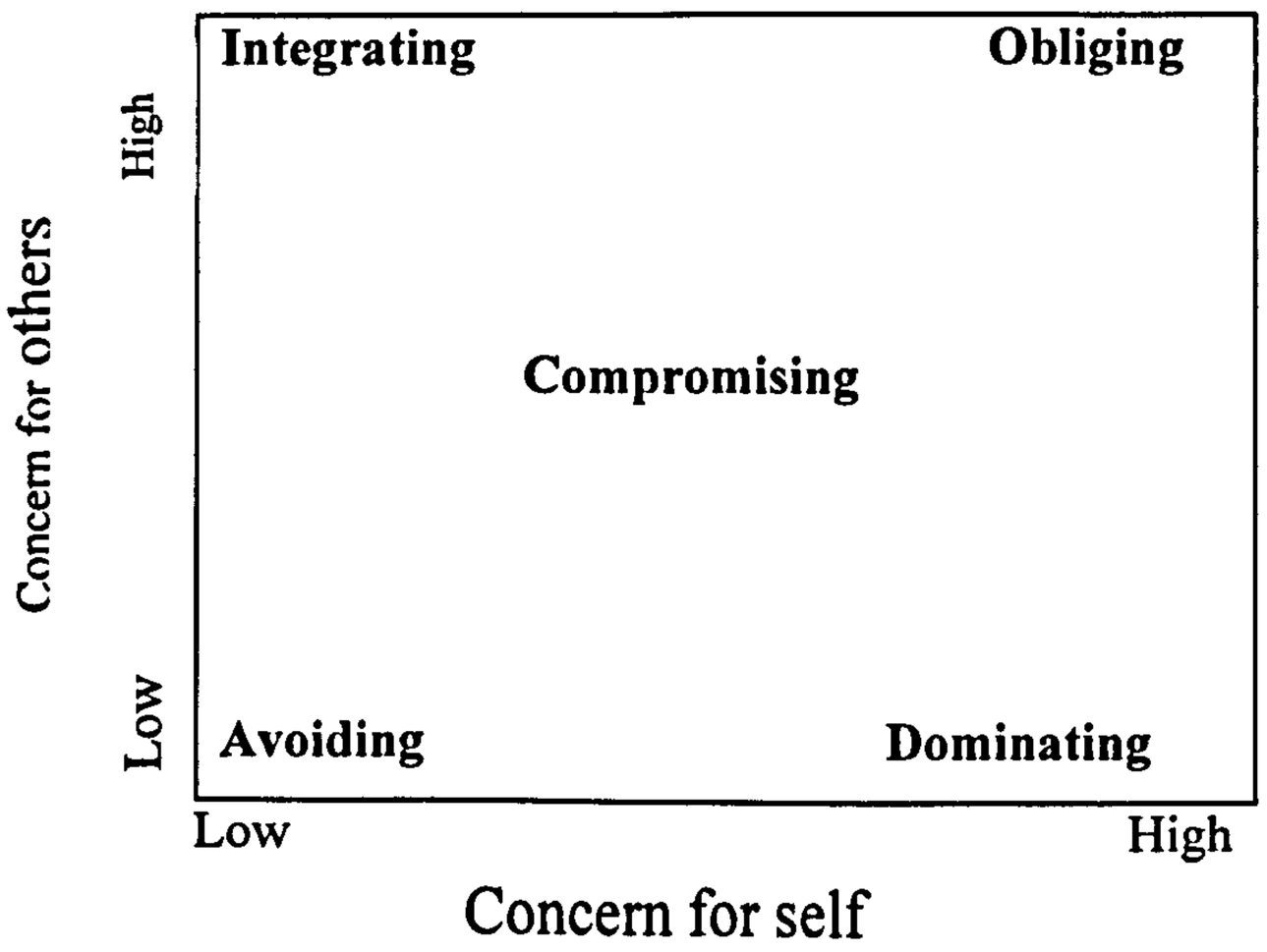

Figure 2.2 : A two –dimensional model of conflict management styles adapted from Rahim (1985)

Chusmir and Mills (1989), after they used a self report questioners to studied the conflict management styles for 201 managers, suggest evaluating styles of conflict management by determining whether the effects of conflict are exacerbated or reduced and whether the outcomes of the tasks are positive or negative. According to them competitiveness and avoidance seem to have a negative impact, whereas collaboration apparently has a very positive one. They find that integrative or cooperative styles of conflict management lead to the most effective outcomes, whereas dominating or competitive styles limit possibilities for achieving desired outcomes.

However Knapp, Putman, and Davis (1988) affirm that even when an individual implements the chosen management tacitly, he or she is not only deciding on the specific tactic used, but is also anticipating the other person's reactions to certain methods. Individuals may exhibit a number of conflict management styles, and no single strategy is likely to be characteristic of an individual. Each strategy may or may not be appropriate for different conflict situations, so the choice of strategy is dependent on the situation and the other party.

This section analyses the concept of conflict and conflict management in general to provide an understanding of the topic in its entirety. The next section will review the literature relating to conflict and conflict management related to nurses and nurse managers.

Section Three: conflict and conflict management within nurse's context

2.3.1 Sources of conflict for Nurse Managers

Nurse managers deal with internal and external conflict daily; indeed conflict is inevitable in everyday social, organisational and professional nursing life (Cavanagh, 1991; McElhaney, 1996). Nursing, like many other activities, is dynamic rather than static, and with that dynamism comes conflict. According to her conflict appears to be an inherent part of the work of nursing. According to Huber (1996) Nurses are prime candidates for conflict because of the need to work collaboratively with people of varying social, ethnic, and educational backgrounds. Health care organisations are particularly vulnerable to conflict because the context and nature of health care

professionals' work may be difficult and stressful (Hipwell et al., 1989). Nurses are at the core of a myriad of interactions in which conflict is present. In clinical environments, conflict among health care professionals is counterproductive to the patient (Forte, 1997).

The presence of conflict among employees can have both negative and positive consequences for organisations. Managers often behave as though serious interpersonal confrontations are the result of personality defects. They label people who are frequently involved in conflicts "troublemakers" or "bad apples". While conflict can be viewed as negative, it has important implications in increasing the effectiveness of a team's decision-making process (Esquivel and Kleiner, 1996).

Many authors try to enumerate the sources of conflict for nurses and nurse managers. Huber (1996) states that the source of conflict can be interpersonal or organisational in nature and lists the areas that causes conflict within nursing. She observes that personal and organisational goals and values may differ regarding general polices, resource allocation, power divisions and the interaction of individual needs with the organisation's needs and goals; conflict may also occur from individuals attitudes, personalities and personal behaviour. Personal behaviour refers to style, mannerisms, or work habits.

Nursing organisations are especially vulnerable to conflict due to the stress of the environment, the nature of the work and the diversity of interactions, workers, and tasks. Moreover, job conflict among staff nurses has a significant inverse relationship with the level of job satisfaction (Gardner, 1992 ; Kunaviktikul, 2000). Health care organisations today face major challenges, including cost containment, competition, downsizing, and restructuring. No organisation is exempt, (Gardner, 1992) notes that these changes are likely to increase conflict in organisations. Organisational conflict occurs over policies and procedures in patient care and personnel management as well as over the accepted norms of behaviour and communication. Tengilimoglu and Kisa, (2005) found in their study that educational differences among hospital staff were a major barrier to good communication and information flow between groups. Resource allocation, a lack of opportunity for career advancement, bureaucracy and the presence of multiple supervisors were all perceived to be a source of conflict. A diversity of players in the delivery of health care services as well as the great variety

of roles and job functions in the delivery of health care services creates opportunity, according to Porter-O'Grady (2004), but she also mentions that the prospect of conflict is raised when there are differences in information, values and beliefs, experience, roles, interests and goals. In her study, Walters (1994) consider communication as an antidote to conflict. Most conflict is rooted in resources limitations, psychological needs, value differences, limited resources such as budgets or supplies, individual promotion and the exclusion of one manager from meetings that his or her peers are invited to attend (Porter-O'Grady, 2004). The majority of conflicts stem from value differences, and are among the most difficult to resolve. Lemieux-Charles (1994) sees the most common sources of conflict as personal differences, lack of information, role incompatibility and environment stress.

The great diversity of people involved and roles and job functions in the delivery of health care services creates opportunities for conflict (Porter-O'Grady, 2004). Inter-professional conflicts between medical and nursing staff have been documented since the time of Florence Nightingale (Kalisch and Kalisch, 1977). The nurse-doctor dyad is an important source of conflict in the nursing unit. Porter-O'Grady (2004) relates the causes of this conflict to the differences in information, values and beliefs, experience, roles, interests and goals. Tengilimoglu and Kisa (2005) refer it to the educational differences among the hospital staff and find that these conflicts are major barriers to good communication and information flow between groups. Kunaviktikul et al. (2000) find that differences in the characteristics of co-workers were the most frequent cause of conflicts between professional nurses in regional hospitals, while the least important cause was the frustration of another party's goal. Management style and staff perspectives and limited staff resources in the unit result in higher levels of stress, differences in goals among groups and competition (Kunaviktikul et al., 2000; Vivar, 2006) Forte (1997) mentions such sources of conflict as differing values, goals and methods, the need for control, a lack of information of role clarity and the need for self protection.

The transition from staff nurse to manager has been identified as a source of conflict and stress, as well as a lack of clarity concerning functions at this level (Oroviogoicoechea, 1996). Conflict can arise from a clash of powerful personalities, uncertainty in the face of change, and the disparity between managerial and clinical

concerns Donaldson (1995). Rahim and Bonoma (1997) point to task structure and group composition and size as sources of conflict. Grady (2003) trace conflict between managers and staff to a lack of understanding regarding expectation, as well as differences in personality. Cox (2001) noted that the team's performance effectiveness, perceptions of unit morale and interpersonal relationships has strong effects on intra-group conflict.

In this section, the literature dealing with the sources of conflict for managers and nurses was discussed. No research was found regarding the source of conflict for nurses and nurse managers in Arab countries. In the next section the researcher will review the literature examining how nurse managers deal with conflict, as well as styles of conflict management.

2.3.2 Nurse Managers and styles of Conflict Management

The changing and turbulent environment in which nurse managers now operate demands from them skills and abilities to guide conflict situations toward constructive outcomes (Hendel et al., 2005). Managing conflict well is one of the challenges nurses frequently face. All nurses, regardless of their position, must effectively manage conflict in order to provide an environment that stimulates personal growth and ensures quality patient care (Forte, 1997).The use of appropriate conflict-handling modes in daily decision-making is one of many challenges facing nurse managers and is influenced both by the individual and the environment in which the person works. Resolving conflict in an effective manner promotes an environment that stimulates personal growth and assists in providing quality patient care (Barton, 1991).

Several studies, (e.g. Mariner's, 1982; Hightower, 1986; Woodtili 1987; Cavanagh, 1988, 1991; Valentine, 1995, 2001; Gardner, 1992; Barton 1991; Eason, 1999; Kunaviktikul et al., 2000; Cox, 2001; Yu Xu, 2004; Hendel et al., 2005; and Tabak and Koparak, 2007) examine conflict management strategies used by nurses at different levels, whether on the clinical side or in management positions, and in academic fields. Research into conflict management is focused primarily on the conflict situation and on the person-situation interaction (Knapp et al., 1988). There is no single way of managing a conflict; this means that there is no single appropriate or inappropriate strategy for dealing with it. It is therefore the responsibility of the

person or group to be conscious of the problem, to select the most suitable strategies depending on the context in which the problem has emerged and to identify and confront conflict at an early stage. The challenge for the leader then is not so much the mere presence of conflict but, when it is recognised in the course of communication, to deal with it effectively and to achieve resolutions (Vivar, 2006). Keenan et al. (1998) notice that both literature and research studies over the last few decades relating to conflict management in nursing are limited. The present researcher found no studies on conflict management styles used by nurses in any Arab countries, and in particular not in the Sultanate of Oman.

Mariner (1982) studied the conflict management profiles of 179 female and three male nurse managers who completed the Thomas-Kilmann instrument (MODE) during a workshop on conflict management. She then compares the profiles with the scores of 339 practicing male managers at middle and upper levels in American business and government organisations that had been surveyed using the same instrument. She finds that nurse managers were slightly less competitive and collaborative, as accommodating, slightly more avoiding than their male counterparts. She also finds that collaboration and compromise were most often associated with effective, and avoidance and competition with ineffective, conflict resolution.

Woodtli (1987) studied the perceived sources of conflict and conflict handling modes for 158 deans of colleges of nursing from 43 states in the USA. She finds that compromise was the most frequent style used, followed in order by collaboration avoiding, accommodation and competing. Several significant relationships come to light in Woodtli's study. For example, deans who use accommodation do not use collaboration, compromise or competition. This study reveals no significant relationships between conflict management styles and demographic variables except for the number of faculty staff but the qualifications and years of experience of the deans participated in this study not mentioned. Using the Thomas-Kilmann instrument (MODE), as did Woodtli, Cavanagh (1988) studies the conflict management styles of intensive care nurses. Her study sample consists of 64 full time female nurses working in four hospitals in the Los Angeles, California area in the USA. She finds both that avoidance was the most common strategy used, and that there was no statistically significant relationship between conflict management styles and other variables such

as age, years of experience and educational background. This finding contradicts what might be regarded as a reasonable opinion, that intensive care unit nurses would be highly assertive. It cannot, however, be generalised to all intensive care unit nurses since the sample is too small and all participants were female nurses only. According to Valentine (2001) there is no difference between male and female nurses in selecting avoidance as the first choice of strategy in handling conflict. Kunaviktikul et al. (2000) conducted a study of 354 professional nurses to investigate the relationships between conflict, conflict management, job satisfaction, intent to stay and turnover of professional nurses in Thailand. Using the MODE instrument, they find accommodation to be most frequently used to manage conflict; 41.2 per cent of the participants used this style while 29.2 per cent employed compromise, 19.5 per cent avoidance 6.9 per cent collaboration and 3.2 per cent competition. Their findings differ from previous ones, a difference they attribute to Thai culture, since other studies in the U.S. find avoidance to be the first choice. According to Kunaviktikul et al. (2000) the Thai religious and hierarchical pattern of relationships could be a contributing factor in the use of accommodation as the style of choice for conflict management, but in this study the researchers not provide the readers information about the type of conflict and source of conflict for the Thai nurses since this is the first published paper about this topic in this culture. Cavanagh (1991) conducted studies to compare the conflict management styles of 145 staff nurses and 82 nurse managers in eight hospitals on the west coast of the USA. She finds that avoiding was the first choice and competing the last for both groups. Nurse managers use compromise as a second choice, while for staff nurses it comes third. Nurse managers prefer avoidance to compromise, the only difference with the staff nurses' choice of conflict management styles. Cavanagh suggests this particular approach seems well suited to the role of nurse manager. When faced with conflict, large numbers of nurses were found to use avoidance, which is an unassertive and uncooperative strategy in conflict management. Caution must be used in generalising these findings because all the participants were female, and gender is an important variable in the use of conflict management. The number of participants, especially nurse managers, was small, and the response rate for the study was only 38 per cent. Valentine (2001) explains that the frequent use of avoidance in managing conflict is related to the sense of powerlessness associated with staff nurses and nurse manager's roles: in their relationships with physicians and upper-level administrators, a power difference is

perceived. For Vivar (2006), nurses use the avoiding style because they still behave according to the traditional paradigm of doctor dominance and nurse deference, because they have a minimal amount of time to argue problems, as they are frequently busy, which hinders communication and inhibits addressing conflict, and because they have little knowledge of conflict management, as the role of leadership is a new type of challenge in nursing and needs better study and practice.

Barton (1991) studied 69 nurse managers at the three levels of assistant head nurse, head nurse and nurse administrator to examine their conflict management styles. She finds that compromising was the most frequently used mode followed by collaborating, avoiding, accommodating and competing. However, the result cannot be generalised to the all nurse managers since the sample size is too small, all the participants are female and the years of experience not mentioned. Using the Thomas-Kilmann Mode Instrument, Eason (1999) conducted descriptive research of 217 registered nurses in the US, 41 per cent of whom worked as nurse manager or supervisor. The results of the study indicate that there is no difference in conflict management styles used by staff nurses or nurse managers. She finds that the most common strategy used was avoidance, with accommodation second; the least common were collaboration and competition. She mentions that effective conflict handling styles must be modelled by nurse managers so that staff nurses can emulate this behaviour. One important variables Eason not mentioned which is, the years of experience for the nurse managers and to compare between the staff nurses and nurse mangers styles this variable is very important. Using an adapted version of Thomas and Kilmann's (1974) conflict mode instrument (MODE), Hendel, Fish and Galvon (2005) examine the conflict management styles of 60 head nurses from five general teaching hospitals in Israel. They found compromising to be the most frequent mode used by head nurses, with collaborating second; accommodating was the least frequent. There was no relationship between most of the demographic characteristics and the style of conflict management used, but the longer tenure the head nurse had in his or her position, the more frequently she/he used collaborating as her/his preferred conflict management style.

The choice of the most appropriate style depends on many variables such as the situation itself, the urgency of the decision, the power and status of those concerned,

the importance of the issue and the maturity of the individuals involved in the conflict (Marquis and Huston, 1996). Rahim (1985) suggests that the effective use of a particular conflict style depends on the situation. Integrating (problem solving) and compromising, for example, are usually best for dealing with strategic (global) problems, whereas the other styles are better for tactical (specific) issues.

Most studies indicate that Western nurse managers prefer compromising, while accommodation was favoured in other cultures. In the five studies of nurse managers, compromising was the most frequent in three (Woodtli, 1987; Barton, 1991; and Hendel et al., 2005) and the second most frequent in the other two (Cavanagh, 1988) and Cavanagh, 1991) nurse manager samples while in the staff nurse studies, compromising was the third in two studies (Washington, 1990; Cavanagh, 1991). These results are in accordance with the significance that women place on relationships and nurses place on caring (Cavanagh, 1991)., but do not embody the values of efficient, technical care that many health care intuitions emphasise.

In summary, all previous research discussed in this section uses the quantitative style in data collection, and no research examines the conflict management styles used by Arab nurses. This therefore reveals a serious gap in the existing state of knowledge which it is the purpose of the present research to fill, firstly by examining the conflict management styles for nurse managers in one Arab country, and secondly by using the focus group as the method of data collection in the second part of this research.

Table 2.2 :Summary of research findings on conflict management styles used by nurses

	Woodtli 1987	Cavanagh 1988	Cavanagh 1991		Barton 1991	Eason 1999	Kunaviktikul 2000	Hendel et al 2005
			Staff	Managers				
Conflict management styles in descending order of frequency	Compromising	Avoiding	Avoiding	Avoiding	Compromising	Avoiding	Accommodating	Compromising
	Collaborating	Compromising	Accommodating	Compromising	Collaborating	Accommodating	Compromising	Collaborating
	Avoiding	Accommodating	Compromising	Accommodating	Avoiding	Compromising	Avoiding	Competing
	Accommodating	Collaborating	Collaborating	Collaborating	Accommodating	Collaborating	Collaborating	Avoiding
	Competing	Competing	Competing	Competing	Competing	Competing	Competing	Accommodating
Population	167 deans	64 female nurse	145 staff nurse	82 managers	69 different levels	217 registered nurse	354 registered nurse	60 nurse managers
Methods	Quantitative	Quantitative	Quantitative	Quantitative	Quantitative	Quantitative	Quantitative	MODE
Instrument	MODE	MODE	MODE	MODE	MODE	MODE	MODE	

2.4 Culture and conflict Management Styles

In the social sciences, culture is a vital concept. In the study of human behaviour in particular, culture is often the core since it constitutes the framework in which behaviour emerges (Boonsathorn 2003). Hofstede (2001) defines culture as "collective programming of the mind that distinguishes the members of one group or category of people from another" (p.9.). Bodley (1994) stated that culture involves at least three components: what people think, what they do and the material products they produce. Thus, mental processes, beliefs, knowledge and values are aspects of culture.

Culture is learned, not biologically inherited, and involves arbitrarily assigned symbolic meanings. Culture refers to the whole way of life of the members of a society. "Culture includes how they dress, their marriage customs and family life, their patterns of work, religious ceremonies and leisure pursuits. Culture affects the way that people make decisions, think, feel and act in response to the opportunities and threats affecting the organisation "(Barthorpe, 2000 p. 337). The variables that most frequently characterise culture are language, religion and geographical location (Elsayed-Ekhouly, 1996). Culture itself is a contributing factor to what makes one organisation different from another. It is the soul of an organisation – its nature, its personality. It is, therefore long-term and very difficult to change.

In his study about work-related value in more than 50 countries Hofstede (2001) categorised the cultures as individualism-collectivism. Individualism-collectivism mirrors the relationship between individuals and their membership groups. There are key descriptions that differentiate individualists and collectivists. People from individualistic cultures such as northern European ones and their cultural descendents such as the US and Australia are more worried about individual's goals, privileges, wishes, and successes than with those of their group.

People from collectivistic cultures, which include Arab countries, Greece, Brazil, and Japan, give more importance to the group's goals, privileges, wishes and successes than the individual's. They see themselves as mutually dependent with their community and use community norms and regulations as direction for how to behave. For collectivists, self-confidence derives from being acknowledged and approved by in-group members such as friends, family, and relatives (Hofstede, 2001).

The differences regarding conflict may emerge from attitudes toward conflict. For members of cultures in which individuals is relatively more important than their context, conflict progresses according to a problem-solving model. Conflict serves as a way through which one can express differences. It can be dysfunctional or functional. Conflict is dysfunctional when suppressed or not addressed directly; it is functional when it creates an opportunity for solving problematic issues. Individualists feel that one should deal with substantive and relational issues independently. Open and honest discussion about conflict is of value, and effective management of conflict should result in a win-win situation. In contrast, collectivistic, high-context cultures have a different basic attitude toward conflict, which they regard as dysfunctional. It is an embarrassing, distressing and destructive force that can damage the prestige and harmony of the members of its society, and it should therefore be avoided (Boonsathron 2003). Individualists are more outcome-oriented than are collectivists and the importance given to the one's own goals and wishes. Their main concern in conflict situations is to shift quickly to reach a real goal. Individualists prefer to discuss conflict openly, whereas collectivists prefer a subtle negotiation to preserve pride and the relationship of the parties involved (Ting- Toomy, 1999).

Ruble and Schneer (1994) report that in the conflict management process culture defines the values and interests at the root of each conflict; this culture also shapes people's perception of themselves and others, as well as the style with which they handle conflict. A number of studies have shown how styles of conflict management are affected by culture (Leung, 1988; Kramer, 1989; Kozan, 1989, 2002; Ting-Toomey et al., 1991, Elsayed-Ekhouly, 1996; Ting-Toomey, et al., 2000; Lee 2002; and Boonsathon 2003). Significant relationships have been found between cultural background and styles of conflict handling. (Rahim, 1986) reports that individualist cultures may select a distributive dimension to resolve their interpersonal conflict - that is, they may use either a dominating or an obliging style which is indicative of a perception of the ratio of satisfactory resolution of the concerns felt by the self and the other party. If the individual belongs to a collectivistic culture, s/he may use an integrative dimension, in which an integrating or avoiding style of handling conflict indicates a perception of the extent to which both parties are satisfied. Compromising reflects the point of intersection of both dimensions where individuals receive an

intermediate level of satisfaction of their concerns from the resolution of their conflicts.

Some evidence that national culture influences the style of handling interpersonal conflict was demonstrated by Ting-Toomey (1991) in the results of a field study conducted in five countries, which indicated that U.S. respondents reported greater use of a dominating style than Japanese or Korean respondents, whereas Chinese and Taiwanese respondents reported greater use of obliging and avoiding styles than the U.S. respondents. Leung (1988) examined the prefernce particularly for avoidance conflict styles among Americans (high in individualism) and Hong Kong Chinese (who were high in collectivism); the results reflect Ting-Toomey's and Rahim's propositions that, in general, people from collectivistic/high-context cultures favour avoiding more so than their counterparts from individualistic/low-context cultures.

In a study of ethnic/cultural identity salience and conflict styles, Ting-Toomey et al. (2000) found that individuals with a strong cultural identity use integrating, compromising and emotionally expressive styles more and neglecting styles less than individuals with a weak cultural identity in four U.S. ethnic groups. However, Boonsathorn (2003) used ROCI II and individual interviews to compare Americans and their Thais counterpart and found that the Americans preferred to used integrating and compromising while the Thias prefer to used avoiding and obliging. She concluded that there is a effect for the national and organisational culture on the ways people deal with conflict. Using the same tool (ROCI II), Kozan (1989) surveyed the conflict management styles of 215 Turkish and 134 Jordanian managers. He found that managers in Turkey and Jordan demonstrate a resemblance to each other and to their U.S. counterparts in reporting a clear preference for a collaborative style in handling conflicts. The Jordanian managers preferred collaborating, compromise, accommodation, avoiding and forcing, while Turkish ones used collaborating, forcing, compromising, avoiding and, accommodation. Turkish managers primarily use a forcing (dominating) style with subordinates. This also showed that Jordanian managers mainly compromise with peers. Subordinates are most likely to use an obliging style when handling conflict with a superior because they tend to say what is acceptable rather than what they think is true (Rahim, 1983). Kozan's (1989) survey also showed that Turkish managers primarily use an accommodating (obliging) style

with superiors. Kozan (2002) examines the role of subculture in conflict management style in 40 organisations in Turkey, and found no difference in the choice of problem solving style. However, preferences for other styles differ across subcultures.

Lee (2002) investigated the conflict management styles used by Korean government employees with superiors, peers, and subordinates. He found that dominating was used more frequently with a subordinate, compromising was with a peer, and obliging and avoiding with a superior.

Elsayed-Ekhouly (1996), the first researcher to compare Arab Middle Eastern executives with their U.S. counterparts, reported that no studies had been conducted on styles of handling conflict in Arab Middle Eastern countries, but Kozan (1989) studied the conflict management styles used by Turkish and Jordanian and compared the results with American managers. Elsayed-Ekhouly's sample comprised 779 Egyptians, 220 of whom were female, 134 male executives from the Gulf area and 144 American executives, 75 of whom were female. The results indicated significant differences between Arab Middle Eastern executives and American ones in all five conflict resolution types. Arab Middle Eastern executives score higher on the styles of integrating and avoiding while American ones scored higher on obliging, dominating, and compromising. Elsayed-Ekhouly stated that culture orientation affects executives' responses to conflicts. Executives from countries which differ in culture tend to adopt different strategies to resolve conflict, develop different anticipations about possible results and are motivated by different causes. Egyptian and Gulf States culture, although very friendly and hospitable, places a high value on privacy. Their culture seems to reflect their stance in the community and at work, and to protect private life by concealing inner feelings and thoughts with a bland exterior. This makes it difficult for executives from Egypt and Gulf states to openly deal with conflict. Kramer (1989) indicates that the Gulf States may be characterised by centralised decision-making, and this characteristic may lead to expectations of more assertive and less accommodating styles toward subordinates. Arab Middle Eastern managers are most likely to seek alternative options to dealing with conflicts whose resolutions are capable of integrating the basic needs and interests of adversaries (Elsayed-Ekhouly, 1996).

2.5 Conflict Management styles studies in Arab Countries

Conflict management styles used by nurses have not been studied by researchers in Arab countries until now, unlike comparisons of conflict management styles of Arab managers with those in other countries. There are few published studies regarding conflict management styles in Arab countries, and some unpublished postgraduate and PhD theses. The majority of studies in Arab countries (summarised in table 2.3) have been conducted in the field of education, with a few in business, but there have been none examining conflict management styles used by health workers in general or nurses in particular.

Using Thomas and Kilmann's (1974) conflict mode instrument (MODE) Al Bawab (1986) explored the conflict management styles used by secondary academic school principales in Jordan. His sample consisted of 125 principals. He found that the participants use all styles in their conflict management, with collaborating (integrating) most favoured, followed by dominating, avoiding, obliging and compromising. Female participants used compromise more and obliging less than their male counterparts. The researcher used a translation of MODE without explaining the translation process; neither did he clarify whether the items were changed according to the culture, or whether he kept the same terms throughout. It is also not clear how he collected the data, and whether he distributed it by post, visited the school or acted in the official way; the answers to all of these would affect the results of his research, Because the MODE items is a culture sensitive and can be understood in more than one meaning. Also if the sample is selected randomly or selected purposely to fit this research, then the readers can decided about the generalization of the results

Al Belbeisi (2003) used ROCI II to explore conflict management styles used by public secondary school principales in Jordan and their relationship to teachers' morale and organisation commitment. She sampled 560 teachers of both genders, and finds that teachers perceived their schools' principals to use all conflict management styles. The integrating style was most used, with a mean of 4.45, followed by compromising at 4.44, avoiding at 3.28, dominating at 2.22 and obliging at 2.17. The researcher here explored the styles used by managers from their teachers' point of view using ROCI

II, which is best suited to reflecting the participants' own experiences. This researcher measures no differences in age, gender or other variables.

Harem (2003) conducted his study in private Jordanian banks to explore the conflict management styles used by employees. The instrument containing 20 items reflected the five conflict management styles. His sample was 550 employees from five banks, who use integrating most frequently, with a mean of 4.01, followed by compromising at 3.77, avoiding at 3.27, dominating at 3.12 and obliging at 2.8. Harem's (2003), Al Belbeisi's (2003) investigations led to the same findings using different instruments with different participants in different fields from the same culture. Harem (2003) found a difference in conflict management styles according to management level, age, educational level and years of experience and correspondence between style of conflict management and gender.

Dmour (2004) measured the conflict management style used by educational supervisors in Jordan. His instrument consisted of 40 questions and his sample of 314 educational supervisors. This instrument identified six conflict management styles, as opposed to the usual five. He found that the participants used all conflict management styles but, similarly to Al Belbeisi (2003), that they preferred integrating, with a mean of 4.09, followed by compromising at 3.58, reporting the problem to a higher authority at 3.45, obliging at 3.41, avoiding at 3.14 and dominating at 3.10.

Qatan (2001) conducted a study regarding organisational conflict management styles among school principals in the Sultanate of Oman. She developed a list of 42 items and measured six styles of conflict management, the usual five and reporting to a higher authority. Her sample consisted of 102 males and 82 females. The participants use integrating, compromising, obliging, dominating, reporting to a higher authority and avoiding in that order. She also found a relationship between conflict management styles and gender, but no correlation between educational levels and conflict management styles. The research sample is drawn from all regions in the Sultanate of Oman, but it is unclear if all participants were Omani or whether some were of different nationalities. The researcher distributed her questionnaire through the Ministry of Education and the participants dealt with it as a Ministry job or request; the resulting attitude would undoubtedly have affected the research result.

There have been no studies of the styles of conflict management of managers in Oman in nursing or in any other field. This study will fill that gap, being the first to explore the conflict management styles used by nurse managers in Sultanate of Oman.

Table 2.3: Summary of research finding on conflict management styles in Arab culture

	Al Bawab 1986	Qatan 2001	Al Belbeisi 2003	Harem 2003	Dmour 2004
Conflict management styles in descending order of frequency	Integrating Dominating Avoiding Obliging Compromising	Integrating Compromising Obliging Dominating Report to an authority Avoiding	Integrating Compromising Avoiding Dominating Obliging	Integrating Compromising Avoiding Dominating Dominating Obliging	Integrating Compromising Report to an authority Obliging Avoiding Dominating
Population	125 Academic	184 Academic	560 Academic	550 Bank employees	340 Academic
Instrument used	MODE	self developed	ROCI II	self developed	self developed

2.6 Gender and Conflict Management Strategies

In addition to the culture dimension discussed earlier, group differentiation by sex can be considered as subcultures within a broad cultural context and gender represent one of the variables in which researchers concerned with conflict and its resolution are interested.

Gender is a wider concept than sex. Gender implies looking at women and men, and at their health, from a social, psychological and cultural perspective (Risberg et al., 2003). Klenke (2003) proposes that gender's impact is exerted through differences in the use of power by males and females, organisational politics, conflict management styles and trust, all of which affect decision-making outcomes. Wilson (2002) states that it is evident that some jobs are more gender-based than others and that men and women do not leave their socialised roles behind them when they enter the world of work. It is deemed self-evident that nursing is a woman's role, but Korabik, Baril and Watson (1993) use the term gender in their research because they believe such differences result largely from culture or experience rather than biology.

Vincent (2003) states as a sociological concept that gender is nothing more than a set of beliefs and perceptions about what is feminine and what is masculine. Shockley-Zalabak (1981) note that perceptions of how females handle crisis and conflict are often cited as blocks to a female manager's ascent to the executive suite and boardroom (p.289). According to cultural stereotypes, women are expected to be more obliging, considerate and compassionate in conflict resolution situations compared to men, who adopt an aggressive, dominant, independent style in such situations. From a review of relevant scholarly literature and role theory, Chusmir and Mills (1989) reported that men and women from the same management level used the same conflict management styles at work but not the same style at home According to Miller (1991), women manage conflict by using a more interdependent criterion based on interpersonal obligation, while men used a more independent one based on

rights. He concludes from this that women conceive morality from a different perspective than men.

Previous research has addressed the question of whether men and women perceive themselves to have similar conflict management styles. Such research has produced contradictory results; some studies supporting the long-standing assumption, based on cultural stereotypes, that women have a more cooperative orientation to conflict than men and those men are more competitive than women. Other studies, however, are not totally consistent with these findings – or, indeed, with each other. Results regarding gender and choice of conflict resolution strategies have often shown women to prefer more collaborative, compromising, avoiding and accommodating strategies, while men tend to exhibit competitive styles (Miller, 1989). But Chusmir and Mills (1989) find no significant gender difference in the conflict resolution styles of American managers at work and at home. Korabik, Baril and Watson (1993) also find differences between the preferred conflict management styles of women in managerial and non-managerial positions,but not from men, who are managers, the sample in their study was 196 students enrolled in MBA evening classes. They account for the differences between women managers and non-managers in two ways. Firstly, women managers are a highly select group who do not confirm to the typical female stereotype. Secondly, women managers may also undergo a socialisation process whereby they become more like men. But by using the Thomas-Kilmann Mode instrument to examine the conflict management styles of 102 female and 99 male managers at work and at home to determine the differences in the handling of conflict in each of theses sites, Chusmir and Mills (1989) found that there are differences between the genders. The subjects were chosen from not-for-profit and for-profit organisations and at low, middle and upper-level management positions. The results show that, regardless of the position held, female managers scored highest in compromising, followed by avoiding, collaborating, accommodating and competing, while male managers used collaborating, followed by compromising, avoiding, competing and accommodating. At home, female managers used compromising most often, closely followed by accommodating, collaborating, avoiding and competing. Male managers scored highest in

accommodating, followed by collaborating, avoiding, compromising, and competing.

Rahim (1983) studied the conflict management styles used by 50 female and 50 male managers in business industry in the United States. The women report using compromise more than men, and there was no gender difference regarding competing or dominating. He also found that men reported being more obliging (accommodating) than women, who in turn were more avoiding and integrating (collaborative) than men. Mackey (1998) examined the marital conflict management styles and the role of gender and ethnicity using Rahim's Organisation Conflict Inventory II. He found a difference between the sexes in the early and child-rearing years, in which a majority of husbands avoid face to face discussion of conflict whereas a majority of wives use confrontational styles.

According to Miller (1991), women manage conflict by using a more interdependent criterion based on interpersonal obligation, while men used a more independent one based on rights. He concluded that women perceive morality from a different perspective than men. Cetin and Hacifazhoglu (2004) compared the conflict management styles of 150 academics and 130 high school teachers in Turkey. They found that men are more rigid than women and try to avoid personal conflict.

Using the Thomas-Kilmann Conflict mode instrument, Brahnam et al. (2005) examined the difference in conflict management styles between males and females for 163 undergraduate information system students in one university in America. They found that females collaborated more than the males, and males avoid conflict more than females. The latter prefer compromising, with a mean of 7.32, collaborating at 6.023, avoiding at 5.65, accommodating at 5.62 and competing at 5.279. Males preferred to use compromising at 6.992, followed by avoiding at 6.46, accommodating at 5.95, competing at 5.50 and collaborating at 4.975. These findings indicate that female students are highly adapted with regard to their ability to work collaboratively in situations where conflict is likely to occur.

There are no studies in the nursing fields examining the difference in conflict management styles between males and females except Valentine's (1995, 2001). In her 1995 article she concludes that women and nurses frequently use the conflict management strategies of compromising and avoiding and she explains that, because women have been socialised to depend on others to meet their emotional needs and to value support, they see conflict as a distancing behaviour that may result in rejection and/or abandonment. And in 2001 she supports her findings and adds that gender may influence a nurse's choice of conflict management strategies. Women are generally socialised to be more concerned with interpersonal aspects of relationships than are men. Female nurses tend to view handling conflict as a way to seek confirmation and support while also attempting to maintain harmony.

In previous studies conducted in the context of Arabic culture, Qatan (2001) found that Omani males use avoidance more than females; there are also differences in the use of the other styles. Bawab (2001) found that the female principle is more compromising and less obliging than the male, while Harem (2003), Belbeisi (2003) and Dmour (2004) saw no difference between males and females in their selection of conflict management styles.

In conclusion, all research conducted in Arab countries uses quantitative methods to collect data. No research has been conducted to explore conflict management styles used by nurse managers. This research fills this gap. It will explore the conflict management styles used by nurse managers where it has not been explored before, and will use the qualitative method, not used in any of previous study.

2.7 Other variables in conflict management styles

2.7.1 Conflict management styles and management level

Hofstede (1991) views Arab cultures as having a high level of power distance, which he describes as "the extent to which the less powerful members of institutions and organisations within a country expect and accept that power is distributed unequally" (p. 28). The term "power distance" refers to how the public in some cultures care for and value others according to their social

position and his status (Ting-Toomey, 1999). In high power distance cultures (e.g. Malaysia, India, Philippines and Arab countries) people with high position expected to receive special treatment from the community according to their position. On the other hand, in low power distance cultures (e.g. Denmark, Australia, and the U.S.) all the people receive the same treatment regardless of their post or position.

Positions of power are found to have a significant influence on the conflict management styles used. Rahim (1986), in developing his own management scale, found significant differences in style among low-, middle- and top-level managers, but his sample consisted almost exclusively of males. Kozan (1989) reported that Turkish managers are more forceful towards subordinates, more avoiding towards peers and more accommodating towards supervisors. Harem (2003) found a difference between department heads and bank administrators in using the avoiding style: department heads used it more than administrators, with a mean for the former of 3.27 and for the latter of 2.28. He also found that as the participants' management level increases, so they appear to use the dominating style more, with a mean of 3.05 for staff, 3.25 for department heads and 3.65 for administrators. Chusmir and Mills (1989) found no difference in conflict management styles for males or females between the three management levels.

Barton (1991) found that assistant heads of nursing reported a higher mean use of avoiding than did head nurses or nursing administrators. This may be due to the fact that their entry-level management position placed them in the role of subordinate more frequently than members of the other two management groups. Nursing administrators favoured the competing mode, ranking it second, while assistant heads of nursing used it last. This was most likely because nurse administrators are responsible for making quick decisions which may be unpopular. It is interesting to note that the most assertive mode (competing) and most cooperative mode (accommodating) were those used least frequently by the majority of nurse managers, indicating that they are more comfortable using strategies that incorporate a blend of assertive and cooperative behaviour.

2.7.2 Educational Level

According to Qatan (2001) and Dmour (2004) there is no significant relationship between educational level and the selection of conflict management styles. Al Bawab, on the other hand, found that school principals with higher educational levels were less obliging, and that the use of collaboration rises with the level of experience.

Harem (2003) found no relation between educational level and avoiding. But there was a clear correlation between the dominating style and educational level, since they both increased in tandem. The dominating mean for staff without a university degree was 1.75, while for those with a first degree it was 3.19 and 3.44 for those who had a postgraduate qualification. There is also a clear correspondence between the integrating style and the level of education: participants without a university qualification used integrating less, at a mean of 2.25, than did those with a first degree, at 3.832, and those with a postgraduate qualification at 4.013.

2.7.3 Years of experience

According to Harem (2003) there is no relationship between the avoiding and dominating styles and years of experience, but there is one between this factor and the other four styles. There is a positive relationship between obliging and years of experience, with a mean of 2.62 for participants with more than 15 years of experience and 2.91 for participants with five years and less. Participants with more than 15 years of experience use compromising, at 3.899, more than do the others: participants with five to ten years of experience have a mean of 3.54 and those with five years and less have 3.79. Revilla (1984)(cited in Chusmir and Mills, 1989) reported significant differences due to management experience. The more experienced administrators were more competitive, less compromising and more assertive than the less experienced ones. Qatan finds that principals with eleven years' experience and more use dominating more than do those with less than three years' experience; there are no differences in other styles. Cetin et al (2004) found that experience did not create a difference among teachers' conflict management styles. But academics with 11-20 years of experience used compromising more than those with less than five years'

experience, and academics with 21 and above years of experience and similar finding to the collaboration styles.

2.7.4 Age

Harem (2003) found a relationship between age and the use of avoidance, obliging and dominating conflict management styles, but no relationship in the case of integrating and compromising styles. For those participants younger than 20 years old the mean for avoidance was 4.5, for those aged 30 to 40 it is 3.217, and for those over 40 it is 3.26. The mean for the obliging style was 2.55 for those aged 40 and over, and 2.84 for the 20-40 age groups. There was a positive relationship between the dominating style and age. The dominating mean is 2.13 for the group aged less than twenty years, 3.026 for the age group 20-30, 3.18 for those aged 30-<40 3.35 for the over-40 age group.

Cetin et al. (2004) found that age was one of the most important variables affecting conflict management styles. In their study, both teachers and academics aged 41 to 50 had positive attitudes towards different views; they conclude that the older the individual, the more accommodating they became in interpersonal relationships.

2.8 Summary

Conflict is an important concept for nursing. It is part of everyday life, and it is inevitable. Conflict and conflict management styles is a field of study in all disciplines. No simple and standardised definition for conflict exists, even if all scholars have agreed that it is present. There are four types of conflict and five stages in which it happens. Some scholars consider that conflict is bad, others good, and yet others see its value as dependant on how it is managed. Conflict is important for productivity in organisations; its relationship is described as an inverted U shape. Several factors, personal and environmental, influence whether or not conflict occurs.

Even though conflict appears to be a common phenomenon in human experience, each person deals with conflict situations differently. Conflict management is identified, described and categorised in a variety of ways by different scholars, but most have identified five basic styles of conflict

management, however they are known. These five styles measure two dimensions, the concern for self (assertive) and the concern for others (cooperative).

The findings of previous researchers differ according to the population's culture, gender and discipline. Specifically, there is a need to explore the conflict management styles used by nurse managers in the Sultanate of Oman since, according to the present researcher's best knowledge no research has been conducted to examine how these styles used by nurses either in Oman or in any other Arab country. This research will fill this gap.

Chapter Three: Method and Methodology

3.1 Introduction

The aim of this study was to explore the style of conflict management used by nurse managers in the Sultanate of Oman and that style's relationship to some demographic variables. More specifically, the following questions were addressed during the data collection and analysis;

- What is the relationship between age and conflict management styles?
- What is the relationship between gender and conflict management styles?
- What is the relationship between the number of years of experience as registered nurse, nurse managers and managers in this post and conflict management styles?
- What is the relationship between nurse managers' educational preparation and conflict management styles?
- What is the relationship between the nationality of the participant and conflict management styles?
- What is the relationship between management levels within nursing departments and conflict management styles?
- What is the relationship between the nurse managers marital status and conflict management styles?

This chapter aims to explain and justify the methods and the underlying methodology used in this research. An explanation of the study's research design and guiding research paradigms, including a rationale for triangulation, will be examined. The chapter reviews the techniques used to collect the baseline data, including the survey packages and the focus group interviews, with sections regarding validity, the pilot study and reliability. The implementation of the data collection process and the statistical techniques used in the analysis of data are then described, and the ethical issues related to this research are critically reviewed.

3.2 Research Methodology

This study was designed to explore the conflict management styles used by nurse managers in the Sultanate of Oman. In addition to exploring the styles, other variables such as gender, age, years of experience in the current post and years of experience as a manager will also be examined to determine how they might influence the individual's style of conflict management. Like all aspects of nursing study, this research is performed in a complex field, with many interrelated factors to consider when designing research and developing methodology. The researcher will explore the various research methods to find the appropriate ones for the present study. Easterby-Smith et al (1997) give three reasons why the identification of an underlying philosophy may be significant, with particular reference to research methodology:

- It can help the researcher refine and specify the appropriate research methods.
- Knowledge of research philosophies will enable the researcher to evaluate different methodologies and methods and avoid inappropriate use and unnecessary effort by identifying the limitations of a particular approach at an early stage.
- It may help researchers to be creative and innovative in either the selection or the adaptation of methods that were previously outside their experience.

The researcher searched for a philosophy and a method suitable to this research which would enable the research questions to be answered, and concluded with Monti and Tingen (1999) that no single method or combination of methods can capture a complex reality in its entirety. Nursing is a multifaceted profession, with many providers of difference educational backgrounds and areas of specialisation who care for many types of client in various situations. One paradigm for nursing science cannot possibly reflect this diversity. According to Monti and Tingen (1999) nursing science is characterised by two predominant paradigms classified as empiricist (positivism) and interpretative (phenomenalism). Proctor (1998) indicates that before any decision on the choice of research method can be made, the two opposing research philosophies must be understood.

3.2.1 Positivism

The positivist philosophy of science emerged in the 19th century, subsequently becoming known as logical positivism, a philosophy of science that evolved to extend knowledge (Easterby-Smith et al, 1997). This paradigm, also called quantitative and scientific, "shaped the development of both medicine and nursing as scientific disciplines" (Easterby-Smith et al 1997, p25).

Positivists are committed to naturalism, the idea that it is possible to transfer the assumptions and methods of natural sciences to the study of social objectives, often referred to as the 'unification of method' (Yates 2004 p.12). Positivist approaches to the social sciences believes that phenomena can be considered as "hard" facts and that the relationship between these facts can be established as scientific laws. For positivists, such laws have the status of truth, and social objects can be studied in much the same way as natural objects (Smith, 1998). The paradigm assumes that there is a body of facts and principles to be discovered and understood and that they are independent of any historical or social context. Knowledge is therefore seen as being totally independent of anybody's claim to it. Monti and Tingen (1999) claim that the positivist approach to study of the social world is based on the hypothetic-deductive method and aims to produce objective data and knowledge developed through sense observation of the natural world. A major criticism of the positivist approach is that it does not provide the means to examine human beings and their behaviours in an in-depth way (Crossan, 2003). It yields useful but limited data that only provides a superficial view of the phenomenon it investigates. Positivism adopts a clear quantitative approach to investigating phenomena.

This approach, fitting with the researcher's perceived frame of reference, seeks to provide hard, objective data based on the assumption that 'fact' to which a variety of analyses and comparisons can be subsequently applied lies ' out there' unaffected by us,. However, in seeking comparisons it can be later applied. In seeking to understand the styles of conflict management used by nurse managers in the Sultanate of Oman, and in particular in the relationship to the variables selected, the researcher recognise the limitations of the positivist approach.

Specifically, conflict management styles are relative to individuals and their contexts; in other words, the term 'conflict management styles' means different things to different people at different times. Another limitation relates to the measure of their experiences during the conflict situation through statistics and the concealment by the data of the richness of their experiences. Real people and their work settings cannot be explored and described only in terms of objective data and the associated statistics, although some aspects of their work can be quantified. Humans are not objective, and their behaviour, feelings, perceptions and attitudes are subject to many influences that positivists would reject as, belonging to the realm of metaphysics, and therefore as irrelevant.

3.2.2 Post Positivism

In opposition to positivist philosophy stand post positivism and interpretive sociology, which identify individuals as active, mindful, aware of what is going on and able to make choices. This philosophy was intially expounded in the first decade of the 20th century. Yates (2004) describes post positivism as 'the assumption that only knowledge gained from observed experience can be taken seriously. If something cannot be directly experienced it is said to be metaphysical – beyond our physical senses' (p.12). The lived experience presents to the individual what is true or real in his or her life. Shih (1998) recognises that post positivism has a richness, holistic analysis, increased validity and depth of description not found in positivism. Morse(1994) points out that during the 1970s post positivism began to gain credence as an approach for nursing research. Beck (1994, p.264) states that, because nursing practice is entwined with people's experiences, post positivism as a research method is ideally suited to the investigation of phenomena important to practice, education and research in nursing. Underpinning this philosophy is an acceptance of the need to develop the same understanding of social situations and activities, and pursue the same constructed shared meanings and interpretations, as the subjects of the research. Proctor (1998) suggests that among the various factors that influence reality, construction, culture, gender and beliefs are the most significant. The present research will be conducted in one country where people from different cultures with different personalities interact as a team to provide a

high quality of nursing care. And the nature of their work and social situation need to be considered where the tool which will be used for the survey developed in different culture under different social situations to affect this, a phenomenological approach is needed for this research.

The researcher, starting from a positivist perspective, increasingly sought the richness which derives from a post positivism approach, while recognising the impossibility of such an approach in its pure form. Therefore, the researcher sought to operate at the interface of these philosophies, as is reflected in the methodological approach adopted. What such a combination can do is to provide an opportunity to move between three different kinds of knowledge: from broad general knowledge to deeper insight; between macro and micro levels in each area and through these to seek knowledge about individual actors' intentions and meanings (Foss and Ellefsen, 2002). According to Shih (1998) the inherent differences between positivism and post positivism are summarised in the following table:

Table 3.1: Differences between positivism and post positivism (Shih, 1998, p 638)

Positivism	post positivism
- The researcher is considered an outside observer and separate from phenomena	- Intertwines observer and phenomena
- Seeks causal relationship	- Many different but equal truths depending upon the purpose of the researcher
- Seeks one truth to explain a phenomenon of interest	- Seeks understanding of the meaning of the phenomena of interest
- Quantitative; context striping assumptions and methodologies - Increased reliability	- Qualitative; holistic analysis - Increase validity.

It appears reasonable for the researcher to accept a positivist approach in order to get a body of quantitative data about conflict management styles used by nurse managers. It is recognised that many individuals within a health service will expect research to be scientifically and quantitatively oriented, although the researcher has recognised a sense of irritation amongst health workers that such an approach does not tell the whole story.

The researcher acknowledges that the two basic philosophies cannot be amalgamated, but by employing a qualitative approach in the second phase as a completion of the study, he has sought to strengthen the value of the research. This can also provide a multifaceted view, since nursing knowledge is multidimensional and complex (Foss and Ellefsen, 2002), but at the same time this may lead the research in a different direction because phenomena that attract attention are not seen as they are outside the field of vision. By using quantitative and qualitative approaches together, the researcher recognised that different styles and methods of research can complement each other in a useful manner. Multiple paradigms stimulate creativity by providing different points of view from which to examine a problem or question (Monti and Tingen, 1999). The researcher recognised that by using such a combination the research may be led in a different direction once phenomena are revealed that would have remained unrecognised by each approach used separately.

3.3 Research Design

Both qualitative and quantitative research methods were chosen because both are suitable for the purpose of this research and for answering the research questions. Shih (1998,) concludes that there are four areas of consideration when deciding on a research method: the philosophical paradigm and goal of the research, the nature of the phenomenon of interest, the level and nature of the research questions, and the practical considerations related to the research environment and the efficient use of resources. The research design serves many purposes: it provides the researcher with a blueprint for studying the research questions, it dictates the boundary for research activity, it enables the researcher to channel his energy in a specific direction, and it also helps him to anticipate

and identify potential problems that may emerge during the implementation process (Carter, 2000). To answer these research questions meaningfully, not only in numbers, and to achieve the objectives, the researcher triangulated different methods, because according to Risjord et al (2001) triangulation yields stronger results than either method could yield alone.

Triangulation provides a multifaceted view (Polit et al, 2001). This method is supported by many authors, each of whom defines it in their own way. Polit, Beck and Hungler (2001 p.313) define triangulation as "the use of multiple referees to draw conclusions about what constitutes the truth". Liehr and Marcus (2002 p.158) define it as "the expansion of research methods in a single study or multiple studies to enhance diversity, enrich understanding, and accomplish specific goals". Denzin (1989) views it as the combination of two or more theories, data sources, methods or investigations in one study of a single phenomenon, and he lists the four types of triangulation (see Table 3-2).

Table 3.2: Types of research triangulation (Denzin, 1989)

Type of Triangulation	Methods
• Data source triangulation	Using multiple data sources (e.g. interviewing diverse key informants about the same topic)
• Investigator triangulation	Using more than one person to collect, analyse or interpret a set of data
• Theory triangulation	Using multiple perspectives to interpret a set of data
• Method triangulation	Using multiple methods to address a research problem (e.g. observations and interviews)

For the research questions under investigation the fourth type (method triangulation) was adopted; using a survey questionnaire and focus group interview. Traditionally, qualitative and quantitative methods belong to different paradigms or worldviews that guide research, and the relationships between the two have even been referred to a 'battlefield of wars' (Tashakkori and Teddies,

1998, p.3). Todays most researchers take the more moderate view that quantitative and qualitative methods can act as partial correctives to each other, although Foss and Ellefsen (2002) warn that combining quantifying and qualifying methods necessarily involves a high degree of complexity, as these methods have fundamentally different epistemological frameworks. Combining different data collection techniques into a single project can be highly productive, but Risjord, Moloney and Dunbar (2000) emphasise that the results must remain independent because the methods do not support each other; triangulation cannot yield confirmation. These authors add that triangulation is useful, but only for completeness. As mentioned before, such a combination could enable a researcher to shift between three different levels of knowledge. Therefore the researcher used a combination of survey questionnaires and focus group interviews, the results of which were independently reached, but which together lead to a better understanding of the problem. The researcher agrees with Barbour (1999) that 'only rarely is multi-method research likely to put equal emphasis on qualitative and quantitative methods' (p.34). The focus group interviews were used to explain the results obtained from the survey, with the caveat that those results may be different in both methods.

Triangulation using multiple methods requires multiple sets of data on the same topic from different viewpoints. Moreover, the techniques used, while being independent of one another, should be focused as closely as possible upon the question to be investigated. Successful triangulation requires careful analysis of each method in relation to other methods, and also in relation to the demands of the research problem. According to Risjord et al (2001), there are three rationales frequently given for using methodological triangulation. The first is completeness; quantitative methods can further develop findings derived from qualitative research and vice versa. The combination of these methods provides a richness and detail that one method alone would not yield. The second might be called abductive inspiration. Qualitative research is often used when a phenomenon is poorly understood. Interviews with participants can orient the investigators within the material. Qualitative investigation can also help organise quantitative data that has already been gathered, or suggest new ways

of approaching the phenomenon. The final, and most controversial, rationale for triangulation is confirmation. Triangulation would yield a stronger result than either method could yield independently. In its most modest form, qualitative methods can tangentially clarify the results of quantitative research. Results obtained from qualitative and quantitative research methods support each other. But not all triangulation will necessary tend towards confirmation; some may indeed lead to a different result. For this study the researcher used triangulation for completeness and in order to obtain the richness and detail from focus group interviews that could not be obtained from survey questionnaires, since conflict management styles are relative to each contextualised individual; in other words, 'conflict management styles' means different things to different people at various times.

Survey questionnaires were used because this method of data collection ensures that the views of individuals translate well into a representation of the total population of interviewees, as well as providing large scale statistics, especially in relation to the main research question regarding the styles of conflict management used by nurse managers in the Sultanate of Oman. Research outcomes have a better known range of applicability. In spite of this, there is a possibility that the survey may not capture what is significant to the participant; consequently, numeric results may be superficial or misleading.

Correlation with the survey questionnaire and focus group interviews can increase the researcher's confidence that a survey has uncovered a meaningful result. One example is the second question regarding the possible difference between male and female conflict management styles. The survey questionnaire requires a simple yes or no answer, but it was the focus group interviews that provided the reason for these differences. The same goes for the other questions. Quantitative and qualitative research methods each compensate the other's weaknesses, and therefore increase the researcher's confidence in the whole study. A combination of both questionnaires and focus group interview techniques gives the research more strength and depth.

Focus groups were chosen because they provided an easy way to collect data, and they took less time compared with the other types of qualitative data collection. Focus groups are a special type of group in terms of purpose, size, composition and procedure. They are a carefully planned series of discussions designed to obtain perceptions of a defined area of interest in a permissive, non-threatening environment. Each group is conducted by a skilled interviewer (researcher) leading six to ten people. The discussions are relaxed, and participants often enjoy sharing their ideas and perceptions. Group members influence each other by responding to ideas and the comments of others (Kitzinger, 1994). Focus group interviews were selected by the researcher because of their easy data collection possibilities and the fact that they take less time compared with other types of qualitative data collection. Another important reason the researcher selected focus group interviews is that the interviews generate discussion that can bring a variety of issues to the fore, and are possibly less influenced by the moderator than one-to-one interviews. Group interaction may stimulate a richer response, but on the other hand may not provide as much in-depth and personal information as one-to-one interviews. Advantages of group interviews are said to include a broader range of responses and elicitation of details that might otherwise be overlooked. They permit a richness and flexibility in the collection of data that are not usually achieved when applying an instrument individually (Morgan, 1988). Some researchers such as Downs (1989) criticise qualitative study as a set of interesting stories "that result in isolated findings that do not advance the discipline because they do not form the basis for further work", and Mays and Pope (1995) criticise it on the basis of its strong susceptibility to researcher bias and its lack of reproducibility . Among other perceived disadvantages are the facts that the focus group interview is not based on a natural atmosphere, the researcher has less control over the data generated, and data analysis is more difficult. The interaction of the group forms a social atmosphere and the comments should be interpreted in that context. It takes some effort to assemble the groups, to avoid sidetracking the discussion onto irrelevant issues, and to ensure that the group is not dominated by its more forceful members (Kidd and Parshall, 2000; Krueger, 1994; and Morgan, 1988). In spite of the disadvantages of the focus group

interview, the application of this method facilitates the collection of interesting data which reinforce the researcher's confidence in the results; as such interviews provide a good source of information for hypotheses or for the construction of frameworks. These in turn allow further investigation (Krueger, 1994; Morgan, 1988).

Table 3.3: Summary of the reasons for the selection of focus groups by the researcher over other qualitative methods

1- Focus group interviews are an easy way to collect data
2- Focus group interviews take less time compared with other types of qualitative data collection
3- Focus group interviews generate discussion
4- The interaction may stimulate a richer response
5- Focus group interviews bring a broader range of responses and elicit more detail
6- Focus group permits richness and flexibility in the collection of data

3.4 Research Instruments

In order to find answers for the research questions, survey questionnaires and focus group interviews were used. For the quantitative survey, the researcher concurred with the review literature in finding that Rahim Organisation Conflict Inventory II (ROCI II) (Rahim, 1983) provides the best tool with which to answer the research questions. With the author's permission, the researcher adapted the instrument and used it as the research tool with a framework for the demographic data.

The questionnaire comprised the following : 1) covering letter; 2) instruction to respondents; 3) consent form; 4) demographic items; 5) the research tool; and 6) an invitation letter sent to three hospitals only to participate in the focus group. Each of these sections is discussed below.

The demographic variables were collected using closed-ended questions. The demographic information sheet included information about age, gender, job position, qualifications, and years of experience in general, years of experience in recent positions and nationality (see appendix A).

Certain aspects of demographic information such as age, years of experience and gender served as independent variables for pertinent statistical analysis. The other demographic information was obtained to provide a better understanding of the characteristics of each participant. Such knowledge may help with determining the scope of the study.

3.5 Validity and Reliability

Conflict management styles used by nurse managers were measured by using an adapted version of ROCI-II (1983). This tool was developed from a sample of 1,219 American managers from different management levels and sectors, 185 of whom were hospital management personnel (Rahim, 1983).

ROCI II (appendix A5) is consists of 28 items and it seems highly valid and reliable, and is used internationally including the Middle East (Kramer, 1989; Elsayed-Ekhouly and Buda, 1996; Kozan and Ergin, 1999; and Kozan, 2002; Boonsathorn, 2003). It consists of a series of items with a 5-point Likert scale (5=strongly agree... 1= strongly disagree) that reflects conflict management styles based on individual disposition. The five conflict management styles reflect different combinations of "concern for self" and "concern for others" (dual-concern model). The items used to indicate the preference for each conflict management style were distributed as follows:

Table 3.4: Items distribution for each conflict management style

Conflict management styles	Items
Integrant (IN)	2,4,5,12,22,23 and 28
Obliging (OB)	1,10,13,17,19, and 24
Dominating (DO)	6, 9,18,21, and 25
Avoiding (AV)	7, 8, 11, 16, 26, and 27
Compromising (CO)	3,14,15, and 20

This tool based on measure indexes the closed preferability of each of the five conflict interaction styles from the point of view of the participant.

The five subscales of conflict style have been tested for reliability. Table 3-5 shows retest reliability coefficients from the collegiate sample, and the internal consistency reliability coefficients, including Cronbach alpha, unbiased estimate of reliability from the managerial and collegiate samples (Rahim, 2004).

Table 3.5: Pearson corrected Item–Total Correlations and Median Intercorrelations of the Items of ROCI–II Subscales

Subscales of Conflict Styles	Corrected Item Total Correlations M	Corrected Item Total Correlations S	Median Intercorrelations IN M	IN S	OB M	OB S	DO M	DO S	AV M	AV S	CO M	CO S
Integrating (IN)	.45–.54	.50–.64	.31	.42	.06	.12	–.05	.07	–.06	.07	.10	.26
Obliging (OB)	.34–.58	.32–.58			.29	.32	–.06	–.03	.14	.14	.11	.11
Dominating (DO)	.34–.54	.32–.55					.34	.41	–.04	–.03	.03	.07
Avoiding (AV)	.45–.57	.47–.58							.34	.38	.08	.04
Compromising (CO)	.47–.62	.38–.47									.41	.33

Note: M = Managers (N = 1,219), S = Students (N = 2,008). Statistics for the collegiate sample is based on the 5,240 ROCI–II Form completed by 2,008 students. (Adapted with permission from Rahim Organizational Conflict Inventory Professional Manual, 2004)

The retest reliabilities of ROCI–II, computed from data collected from the collegiate sample (N = 119) at one-week intervals, ranged from .60 to .83 (P<01). The internal consistency reliability coefficients, which ranged between .72–.76 and between .65–.80 for the managerial and collegiate samples

respectively, were satisfactory.

The test–retest and internal consistency reliability coefficients compare quite favourably with those of other instruments. The retest correlations for the existing instruments range between .14–.57 for Blake–Mouton (1964), .41–.66 for Hall (1969), .33–.63 for Lawrence–Lorsch (1967), and .61–.68 for Thomas–Kilmann (1976) instrument (Rahim 2004).

To summarise, ROCI-II has been universally used and has been shown to have a satisfactory level of reliability and validity. ROCI-II has also been acceptably tested for build, convergent, and distinguishable validity (Rahim, 2000). The preference for conflict management styles was the average of the derived ratings for the questions associated with each conflict management style.

3.6 External Validity

The population for this study was all the nurse managers working in the Ministry of Health in Oman. They were from different countries; it could be possible to generalise the result to similar settings in the region.

The survey questions relating to conflict management style invited the participants to focus on how they actually interact with each other in general. Should this be reflect a suggestion of how the participants perform in real-life. Most probably they would have no reason to not tell the truth about their behaviour. Moreover, the participants should know best how they are likely to act in different situations.

3.7 Standards for Qualitative Research

The qualitative part of the research was subjective. The findings depended mainly on how the researcher formulated the questions, conducted the focus group interviews and interpreted the participants' answers. For this reason cautious must be advised for each decision relating to a given response. The

researcher made his maximum effort to ensure that the standard of the qualitative research set by Lincoln and Guba (1985) was maintained and that this standard included trustworthiness, credibility, transferability, dependability and conformability.

3.7.1 Credibility

The researcher tried to generate valid, correct, and complete data regarding conflict management styles used by nurse managers. Lincoln and Guba (1985) recommended ensuring credibility as one of most important factors in establishing trustworthiness. They discussed a number of recommendations to assist the researcher to maintain credibility. These included prolonged engagement with the data. Moules (2002), suggests that credibility can be attended to by offering the text to other readers so they can explore the interpretations further.

To enhance credibility every effort was made to ensure that the focus groups were representative of all participants in the quantitative part. The researcher tried hard to set aside biases and previous knowledge. Lincoln and Guba (1985) advocate "prolonged engagement" between the investigator and the participants in order for the former to gain an adequate understanding of an organisation and to establish a relationship of trust between the parties. They also suggest developing an early awareness with the culture of participant organisations. In this study, the researcher was familiar with the participants' cultures, he knew all the hospitals, and he was part of the health system.

To guarantee that informants contributed honest data, participation in the focus group interviews was voluntary and each person was given the opportunity to refuse to participate in the study, in order to ensure that the data collection sessions involved only those who were genuinely willing to take part and prepared to offer data freely. The transcript was sent to some of the participants from each focus group who agreed the context; the research supervisor saw the transcript and ended with the same theme.

3.7.2 Transferability

With regard to transferability, the degree to which the results apply to other situations is a critical concern. In qualitative research, the applicability of results are often subject related (Lincoln and Guba, 1985). To help the readers make better decisions, the researcher provides extensive details of the interviewee's personal characteristics to help the reader understand the nature of the samples involved in the interviews. Three focus group interviews were conducted in three hospitals (Ibri, Khoula and The Royal Hospital) in May and June 2006. The first focus group was conducted as a pilot study in Ibri hospital and was attended by eight participants, all Omani. No changes in the questions and content of the focus group were subsequently made, and thus this pilot study was by definition the first focus group. The second group was conducted in Khoula hospital for one hour and was attended by eight charge nurses, four being Omani and the other four Indian. The third focus group, conducted in the Royal Hospital, was attended by four middle level nurse managers, two of them from Oman, one from Jordan and one from the Philippines. The length of the focus group interviews ranged from 60-80 minutes.

With this information, it is up to the reader to agree or disagree with the findings; however, according to Shenton (2004) the accumulation of results from studies staged in different settings might permit the formation of a more inclusive, general picture.

3.7.3 Dependability

Dependability; is the qualitative researcher's equivalent of the conventional term "reliability", which is equal to replicability. In qualitative research reliability means another researcher who conducts the same type of inquiry with similar participants in similar contexts should arrive at similar results (Lincoln and Guba, 1985; Boonsathorn, 2003)). For qualitative researchers, this kind of replicability is impossible to realise because the research design is so flexible and the research findings are produced by constantly changing interactions between researchers and participants. But to maximise the possibilities for replication, the researcher guaranteed confidentiality of the interview data so

that participants would be willing to offer accurate information and opinion relating to the questions. In this situation we can expected the participants are truly reflect their action.

3.7.4 Confirmability

Confirmability refers to the objectivity or neutrality of the data (Polit et al 2001 p.315). In qualitative research, the issue of conformability does not focus on the researcher's description but rather on the quality of the data. Shenton (2004) suggested some steps that must be taken to help ensure, as far as possible, that the work's findings are the results of the experiences and ideas of the informants, rather than the quality and preferences of the researcher. Details of methodological description provided to enable the reader to determine how far the data, as well as any constructs to which it might give rise, may be accepted.

3.8 Population and Sampling

The population for the survey consisted of nurse managers in Ministry of Health referral hospitals at the time of the study. No exclusion criteria were set - that was, all nurse managers from different levels and different hospitals were included.

A sample refers to the group of people that a researcher selects from a defined population, these being the individuals about whom information will be collected (Atkinson, 2000). Polit et al (2001 p. 234) defines a sample as a "subset of the population". In this research study the selected sample was all the population available during the data collection time without exclusion criteria (who's fit with the criteria mentioned in page 18). All nurse managers in the regional and national hospitals in Oman participated in the quantitative part. One hospital, Nizwa, was excluded following the decision of the ethical committee because the researcher worked there as a staff development officer for eight years. The following table shows the total number of nurse managers and the number of responses from each hospital.

Table 3.6: Numbers of participants and response rate from each hospital

Hospital Name	Total number of nurse managers	Total number of responses	% of response rate
Royal hospital	90	82	91%
An Nahdah	25	22	88%
Khawlah	41	39	95%
As Sultan Qaboos	34	19	55%
Ibra	25	22	88%
Sur	26	24	92%
Sohar	30	24	80%
Ar Rustaq	26	23	88%
Ibri	24	20	80%
Total	**321**	**275**	**85.6%**

Four questionnaires were discarded because the participants did not fill in the demographic sheet or answer the tool.

For the qualitative part of the study, the participants involved in the survey were asked to indicate, upon completion, whether or not they were willing to participate in an interview. This form was sent to three hospitals only, which are; Royal, khawalh and Ibri Hospital. These were selected because:

1- The number of nurse managers in two of these hospitals was high and there was more chance to obtain a greater number of participants. The third hospital was near to the researcher's home; the head of nursing there invited the researcher to conduct focus groups with her nurses.
2- The head of nursing in each hospital was cooperative and willing to provide all the facilities and release the participants from duty to attend the focus group interviews.

The forms indicating an intention to participate were handed in separately from the survey to ensure anonymity of responses to the survey items. Efforts were made to make the focus group interviews involve nurse managers from different nationalities to reflect the population of the study. One focus group was conducted for middle level and two for first level nurse managers. The researcher found it difficult to gather as many as for top level nurse managers because of the relatively large distance separating them, as well as their refusal to participate.

3.9 Data Collection Methods

3.9.1 Quantitative Data Collection

Data collection for the quantitative part took place after ethical approval was granted from De Montfort University's Ethical Approval Committee and from the Ethical Approval Committee of Oman's Ministry of Health. The process then proceeded according to the following steps.

1- A letter from the Chancellor's Office of the University of Nizwa was sent to the Director General of Health Services (DG) in each region asking for their support and their permission to allow the researcher to distribute the questionnaire in the hospitals in each region.
2- The researcher then received either an official letter or a telephone call from the each DG granting approval and asking him to visit the head of the Nursing Department in the regional hospital.
3- The researcher called each head as above and arranged a meeting.
4- The researcher visited each hospital on the arranged date and discussed with the head of Nursing (in three hospitals, some nurse managers attended the meeting) the importance of the research and the expected outcome, and gave each of them the survey questionnaires in separate sealed envelopes.
5- Each head filled in a form prepared by the researcher regarding the numbers of beds, nurses and nurse managers. This was necessary

because the Ministry census was not accurate, especially with regard to nurse managers.

6- The head of each nursing department was asked to distribute the questionnaire during the next day's meeting of nurse managers (these meetings are held daily).

7- Each nurse manager was asked to return the questionnaires in the envelope provided to the staff development officer in his or her hospital.

8- After one week, the researcher called the head of the nursing department and the staff development officer in each hospital to find out the number of returned questionnaires.

9- After two weeks, the researcher visited all the hospitals to meet the heads of nursing and the staff development officers, and received all the completed questionnaires in sealed envelopes.

3.9.2 Qualitative Data Collection

3.9.2.1 Organising of the Focus Groups

Focus groups are special types of groups in terms of purpose, size, composition and procedure (Morgan, 1988). They constitute a carefully planned series of discussions designed to obtain perceptions of a defined area of interest in a non-threatening environment in which the expression of different opinions is encouraged. Each group is conducted with four to ten people by a skilled interviewer (in this case, the researcher). The discussions are relaxed, and often participants enjoy sharing their information and perceptions. Group members influence each other by responding to each other's ideas and comments (Kitzinger, 1994). Focus groups are carried out in three stages: planning; conduct of interviews and analysis of the data (Morgan, 1988).

3.9.2.2 Planning for the focus groups

In the planning phase, the researcher considered the study's purpose and developed an interview guide to gather the information. Then a plan forming the basis of the remainder of the research process, including the explanation of the subject and the selection of participants, was developed. According to Krueger (1994) and Morgan (1984), the number of groups is one of the first topics of the

planning phase to be considered, because the group is the main unit of analysis in the focus group research method. That is true in both a statistical and a practical sense. The researchers vary the number of sessions according to which meetings are or not producing new ideas, if the moderator can clearly predict what will be said in the following session, the research is concluded. According to Krueger (1994) and Morgan (1988), this usually happens after the third or fourth session. The plan in the present research was to conduct four focus groups, two for first level and one each for middle and top-level nurse managers. After the third session, the participants started repeating the same words, so the fourth session was not conducted. The researcher also found it difficult to call the heads of the different hospitals' nursing departments together; in fact, they refused, because the distance between the regions was too great.

The size of the groups should be small enough so that each person has a chance to share perceptions, and big enough to provide a variety of opinion (Krueger, 1994; Morgan, 1988). Large groups are more difficult to manage, it is harder to maintain control, and usually need more moderator involvement in particular to reduce parallel chat. The literature presents various opinions on the optimum size of focus group. Some suggest that a size of six to ten members is appropriate (MacIntosh, 1993), but some researchers have used up to sixteen (Winslow et al., 2002) or as few as four (Kitzinger, 1994). Others propose that the number of questions, the subject, and time fixed for a session should be factored into the decision about the group size (Strickland, 1999). In the qualitative part of the present research, the aim was not to display statistical significance, or to generalise to a larger population but rather to collect rich information, to inspect meanings and to describe the nurse managers' behaviours regarding conflict management. In order to effect this purpose, sampling was used in the selection of the focus group participants. The researcher attached one form with the questionnaires asking the nurse manager to participate in the focus group and these invitations were sent to the nurse managers in three hospitals. Around 34 nurse managers agreed to participate in the focus groups. In the first and second groups, 12 nurse managers were invited and eight attended, while in the third focus group, which was conducted in the Royal Hospital, 20 nurse

managers agreed to participate but only four actually attended the discussion since the others were either busy or on leave. All the focus group interviews were conducted during working hours using the facilities provided by the heads of the nursing departments.

According to Kruger (1994), homogeneity among the participants should be reinforced by the moderator in the introduction to the group discussion. Morgan (1988) advised that group homogeneity should be maintained in order to give each participant the chance to say something on the topic and to feel comfortable in discussion. Introducing hierarchies into a focus group means that some members will not speak, and will allow senior members to dominate (Kitzinger, 1994). To maintain homogeneity in this research each focus group attended by the same level of nurse managers; two focus group interviews were attended by first level nurse managers only and the third by middle level nurse managers only.

The focus groups were conducted in the conference room in each hospital. This was an easy location for the participants; this room is equipped with chairs and a U shaped table. The researcher arranged with the nursing management in each hospital and the head of nursing booked the conference room and confirmed the date and place with the participants.

The researcher took the role of moderator during the discussions. The interviews were recorded using an MP3, and were then downloaded onto the researcher's computer.

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3.9.2.3 Conduct of the focus group interviews

Morgan (1988) presents four aspects to be observed in the focus group interview. They are: (1) to cover the most number of important topics; (2) to make the data as precise as possible; (3) to encourage communication that explores the participants' feelings in some depth; and (4) to take into account the personal background in which the participants generate their responses to the

topic. To begin the focus group discussion, the researcher introduced himself as the group facilitator and explained the purpose of the study. Confidentiality measures and audio taping procedures were explained, and written consent obtained. Then demographical data were collected from the participants, including name, age, post, place of work, years of experience and nationality. The members were told that the session would be recorded, after which each participant introduced him- or herself. During the focus group interviews, the moderator directed the discussion with a series of questions (table 3.7)developed after reviewing the literature. Between the questions, the moderator interferes only to clarify any unclear point, to give more explanations or to direct the question to a group member who may not have had an opportunity to speak. All nurse managers attending the focus group participated in the discussion. At the end of each focus group, the moderator summarised the discussion for approval by the group and offered the opportunity for any comments. The researcher followed Morgan's (1988) guidelines for conducting focus groups. All the sessions were treated similarly. The researcher conducted one session as a pilot study. Because there were no changes in the interview guide after this pilot interview, it was used as the first session.

Table 3.7: Guiding questions for the focus group interviews

1	Can you share an experience with us in your workplace leading to a conflict situation?
2	How do you address a situation when you are confronted with conflict in your organisation?
3	How did you handle the situation/ resolve the conflict?
4	In what way have your conflict management styles changed/ or made effect in resolving the conflict?
5	What do you feel about the relationship between conflict management and issues such as age, gender, background and education? What role does it play in managing conflict situations?

3.10 Data Storage

After receiving the participants' replies, the researcher checked the questionnaires to ensure that they were completed. Each questionnaire was

photocopied and labelled, and the data was then entered into the statistical software package SPSS.

All research documents were kept in the researcher's home study in locked metal cupboards to which he has sole access. Computerised information is password-protected.

For the qualitative part, audio tapes of focus group interviews were copied onto compact disc and kept on computer. Other copies of CD and tape recordings were stored in different secure places.

3.11 Data Analysis

3.11.1 Data Analysis of the Questionnaire

A data analysis plan was developed to guide the study's analysis. The plan for this analysis was derived from the research questions, the research design, the method of data collection and the level of measurement of the data. Before selecting suitable tests to be used, data from the demographic questions were consolidated and coded at the nominal level to facilitate analysis. The SPSS computer program was used to aid data analysis. Mean, standard deviations, and percentages were derived for the overall sample and categorised by age, gender, nationality, nursing qualifications, years of experience as registered nurses and as nurse managers; years of experience in this post, and level of nursing management were also analysed. Conflict management styles were measured using adapted version of Rahim Conflict Inventory II (ROCI-II) instrument and non-parametric tests were employed to find the relationship between the variables. One-Sample Kolmogorov-Smirnov was applied to test if the data was normally distributed. The same test was also used to explore the conflict management styles used by nurse managers. A non-parametric Spearman's' rho test, which is the analog of Pearson in the parametric test, was used to test Hypotheses One and Two, and to find if there is any relationship between age in Hypothesis One and years of experience in Hypothesis Two regarding conflict

management style. In both hypotheses there were two variables that were at least ordinal, and an application of Spearman's test would discover any correlation between age and years of experience on the one hand and conflict management style on the other. The Mann Whitney U test, which is the analog of the independent groups t-test parametric test, was used to compare male and female and to examine the third hypothesis, that there are no differences between male and female managers in conflict management styles. To test the remaining hypotheses the Kruskal Wallis Test, the counterpart of the simple one-way ANOVA parametric test, was used, because in each of these hypotheses there were three or more ordinal independent variables.

3.11.2 Data Analysis for the focus group

Focus group analysis is a systematic process (Morgan 1988). Pre-determined protocols were used to facilitate the focus groups. The sessions were conducted sequentially. After each interview, the data was systematically examined in the following six steps.

3.11.2.1 Data Transcription

On completion of the interviews the researcher transcribed them by listening frequently to the audio-tape to familiarise himself with the data in order to gain an understanding of the character of the responses. The researcher also replayed the tapes on some occasions. This allowed him to develop even deeper recognition of the voices of the participants, when later sat and analyse the written transcripts. A maximum effort was made to ensure that the transcripts represented the interview conversations as accurately as possible.

3.11.2.2 Data Management

The interviews were stored on computer, together with recorded and experiences regarding the participants and the focus groups. Each transcript was identified at the top of the first page. The data was stored on hard drive, diskette and printed copy.

3.11.2.3 Reading and Memoing

The researcher familiarised himself with the words of the participants by reading each transcript several times in a relaxed and non-hurried way. The researcher read each file, including the responses until he clearly understood the experiences and perceptions regarding conflict management styles from the perspective of the participant, and for this purpose he made notes in the right-hand margin. Primary codes and cautious topics were also recognised in this phase.

3.11.2.4 Description

The theoretical background that guided this study was described, along with the examination of data related to different variables, so that readers can understand and use their judgment in interpreting the results.

3.11.2.5 Classification

Significant statements in the transcripts regarding the conflict management styles used by nurse managers were selected and treated as of equal importance. The researcher then paid careful attention to the original context of the conflict phenomenon and its management styles in order to extract meaning from each statement. Similar statements were then grouped into "meaningful units".

3.11.2.6 Interpretation

The researcher scrutinised all possible ways of interpreting, categorising and constructing a description of the participants' attitudes regarding conflict management. In this phase, the researcher reflected on his own way description of the conflict situation, how it occurs and how the participants manage it, and develop a description how different people manage conflict according to the culture, gender, age and other variables.

3.12 Pilot Study

3.12.1 Survey questionnaire

The pilot study for the survey questionnaire was conducted in two hospitals with 24 nurses. The criteria of the pilot sample were similar to the population of study criteria. (Pilot studies are needed to test the research process. They aim to determine whether the questions are clear, easy to understand and relevant to participants, and to assess the time needed to answer the questions and to find out how the participants deal with research in general. This pilot was analysed to find out the difficulties faced in analysis and to see if any modifications were needed. The pilot study ran smoothly, all questions being clear and comprehensible, there was enough time to answer them, and the participants evinced an interest in the research topic.

3.12. Focus Group

A focus group interview was conducted in one hospital as a pilot study. The researcher selected one focus group to assess whether the focus group can provide an answer to the research questions. The other objectives of pilot study were to assess if participants could respond to the themes the researcher asked them to address; to assess whether there was any need to make modifications in the study's design and procedure; and to calculate the time needed to cover all the questions.

The pilot study also served as an exercise for the researcher as moderator. Since there were no changes in the questions and the running of the focus group, this group was considered as in the first of the focus group interviews.

3.13 Ethical Issues

3.13.1 Ethical Approval

This research was ethically approved by the De Montfort University Ethical Committee and by the Ministry of Health, Oman.(see appendix). All ethical guidelines set by the Ministry of health were followed. The DMU Ethical

Committee asked the researcher to exclude Nizwa hospital, because he had worked there and had left just a few months before the collection of the data for the current study.

3.13.2 Ethical Consideration

All participants were given an "Information sheet for participants (see appendix. A.1) which provided a comprehensive explanation of the aims of the study, an overview of their rights and the names and telephone numbers of the researcher and of those acting as local supervisor. They were informed that participation in this study was voluntary. Written consent was obtained from every participant in both parts. Details of the interview process were given to each focus group participant and a request to audiotape and written consent was obtained from them immediately prior to commencing the interviews. This tape was discarded after use. It was made clear, before they signed the consent form, that if they wished to stop the tape at any time during the interview, their right to do so would be respected. Moreover, no more questions would be asked and they would have the right to withdraw from interview at any time (one participant withdrew from the first focus group within five minutes of starting).

Only the participants and the researcher were involved in the interviews; no one else was present. In addition, the participants were strongly requested to keep all information they heard during the interview confidential.

A code of research ethics was followed and respected in this research. Various codes of ethics have been developed since the 1950s in response to gross human rights violations. One of the first internationally recognised sets of ethical standards is referred to as the Nuremberg code, developed after the Nazi atrocities were made public during the Nuremberg trials (Polit et al 2001).This was followed by several other international standards.

3.13.2.1 Principle of Beneficence

Principle of beneficence is one of the most fundamental ethical principles in research, this contains many dimensions: freedom from harm, freedom from exploitation, and a risk/benefit ratio. Freedom from harm clearly means that exposing study participants to experiences that result in serious or permanent harm is unacceptable. Researchers must be prepared to abandon the study if there is reason to think that continuation would result in injury, death, disability or undue distress to study participants. While some instances of possible harm are clear, psychological consequences for participating in a study are generally slight and thus require close attention and sensitivity. In this research the participants were not exposed to any harm, and it is clearly stated in the consent form that they can terminate their participation at any point if they feel any harm or discomfort.

3.13.2.2 Freedom from Exploitation

Involvement in a study should not place participants at a disadvantage or expose them to situations for which they have not been explicitly prepared. Participants also need to be secure that their participation, or the information they might provide to the researcher, will not be used against them. The special relationship with the researcher into which participants enter should not be broken. In this study, it was clearly stated in the consent form that the information collected would be used for research purposes only; this was respected by the researcher. The participants were well informed about filling in the form and about the focus group interview process.

3.13.2.3 Risk/Benefit Ratio

Typical major potential benefits to participants include the following (Polit et al 2001, p.77):

- Access to an intervention to which they might otherwise not have access
- Gratification in being able to discuss their situation or problem with a non-judgmental and friendly person
- Increased knowledge about themselves or their conditions, either through opportunity for inspection and self-reflection or through direct interaction with the researcher
- Escape from normal routine and excitement of being part of a study
- Satisfaction that the information they provide may help others with similar problems or conditions
- Direct monetary or material gains through stipends or other incentives

The researcher expects that the participants in the present study, especially in the focus group interviews will benefit from this research because they will have become aware of different styles of conflict management by sharing their experiences with other managers and thereby listening to others ways of managing conflict which they can then apply in their own situations. This benefit became clear from the questions the researcher received after the collection of data, and he subsequently conducted workshops on conflict management in different hospitals at the request of heads of Nursing Departments.

3.13.2.4 Protection of Human Rights

Human rights are the claims and demands that have been justified in the eyes of an individual or by a group of individuals; the term refers to the following rights (Haber2002 p.273):

A. Right to Self-determination

Self-determination means the ability to make choices without them being dictated by any other person or authority; it also means the right to ask questions, to refuse to give information, or to determine the extent of one's participation. The right to self-determination includes freedom from coercion of any type, either by reward or punishment (Polit et al 2001). The participants in

this research were volunteers. The informed consent form they signed before they participated in this research included all relevant information.

B. Right to Privacy and Dignity

Based on the principles of respect, privacy is a person's freedom to determine the time, extent, and circumstances under which their private information is to be shared with or withheld from others. The principle of respect for human dignity includes an individual's right to make informed, voluntary decisions about their participation in a study.

Before conducting the actual study, a pilot study including explanations was conducted to assess the precise amount of time needed for the nurse managers to fill in the form. The participants returned the questionnaire in a sealed unnamed envelope.

C. Right to Anonymity and Confidentiality

Confidentiality means that individual identities of subjects will not be linked to the information they provide and will not be publicly divulged (Polit et al 2001). In this study, each copy of the questionnaire was coded with a code known only to the researcher; the code was used for data collection purposes. Participants received their copies of the questionnaire in envelopes, and returned their completed forms in the same envelope. No question in the survey could identify any participant, because no question included the name of a hospital, a department or (of course) any participant.

D. Right to fair treatment

Based on the ethical principle of justice, people should be treated fairly and should receive what they are due. The fair and non-discriminatory selection of participants is such that any risk or benefits will be equally shared; selection should be based on research requirements and not on the vulnerability or compromised position of certain people. The honouring of all agreements between the researcher and the participants include adherence to the procedures described in advance and the payment of any promised stipends. In this research

all nurse managers participated in the study on a voluntary basis without payment.

3.14 Informed Consent

No investigator may involve a human as a research subject before obtaining the legally effective informed consent of a subject or legally authorised representative. The language of the consent form must be understandable (Haber 2002).

The consent form must be signed and dated by the subject. The presence of witnesses is not always necessary but does constitute evidence that the subject concerned actually signed the form. Generally the signed informed consent form is given to the subject. The researcher should also keep a copy. In some cases when minimal risk is involved, the investigator may provide the subject with only an information sheet and verbal explanation. In other cases, such as a volunteer convenience sample, completion and return of the research instruments provides evidence of consent (Haber 2002). In this research a consent form containing all the elements was signed by the researcher and each participant (appendix A). The researcher also answered all phone calls asking for an explanation of the research.

3.15 Summary

The aim of this study was to explore the conflict management styles used by nurse managers in Sultanate of Oman. The second aim was to examine the relationship between conflict management styles and other demographical factors. The research plan was designed to address these issues. The chapter commenced with a justification of the paradigms and methodologies selected as part of the research plan. The positivist paradigm was selected as the major paradigm because it could provide the objective, quantifiable data required to provide overview of the styles used by nurse managers and the relationship with the selected demographical variables. However, since little is known of conflict management styles used by nurse managers in Sultanate of Oman, the view of nurse managers is crucial in discovering in-depth information. The employment of a qualitative approach in the second phase it will complete the study as well

as strengthening the value of the research. Thus, the interpretivist paradigm was adopted in a secondary role and as a precursor to the major quantitative methodology. This can provide a multifaceted view of conflict management styles used by nurse managers. This chapter has detailed the philosophical underpinnings and practical considerations of the method that have been faithfully adhered to throughout the preparation and execution of this study and writing of this dissertation. The following chapter will provide more details about the data analysis and finding of the research.

Chapter Four: Results

4.1 Quantitative Result

The aim of this study was to explore the styles of conflict management used by nurse managers in the Sultanate of Oman and those styles' relationships to some demographic variables.

More specifically, the next table shows the research questions and research hypotheses addressed in the data collection and analysis.

Table 4.1: List of the research questions and research hypotheses

Research Question	Research Hypothesis
• What is the relationship between age and conflict management styles?	• There is no significant relationship between the age and conflict management styles.
• What is the relationship between gender and conflict management styles?	• There are no differences between male and female managers in conflict management styles.
• Is there a relationship between the number of years' experience as a registered nurse, nurse manager or manager in this post and conflict management style?	• There is no significant relationship between the years of experience and conflict management styles.
• What is the relationship between nurse managers' educational preparation and conflict management styles?	• There is no significant relationship between nurses' educational preparation and their conflict management styles.
• What is the relationship between nationality and conflict management styles?	• There is no significant relationship between nationality and conflict management styles.

Research Question	Research Hypothesis
• What is the relationship between management level within nursing department and conflict management styles?	• There is no significant relationship between management level and conflict management styles
• What is the relationship between marital status and conflict management styles?	• There is no significant relationship between marital status and conflict management styles.

4.1.1 Justification for the data analysis techniques

Descriptive statistics were used as the first analytic technique to reduce the raw data from the completed survey questionnaires into a summary format. The use of this technique was intended to summarise the sample's characteristics including age, gender, years of experience as a registered nurse or nurse manager, years of experience in the current post, nationality, management level and nursing qualification.

Section two of the questionnaire consisted of twenty-eight scaled items on conflict management styles measured with the Likert scale. Nonparametric correlations between variables were conducted to test the correlation of ranks. For the data analysis, computer technology was used as a tool in coding, filing, applying analytical techniques and retrieving information. A statistical package was required that allowed for storage and retrieval of data, an ability to generate descriptive statistics and an ability to perform bivariate procedures. The tools used to assist analysis were SPSS (Statistical Package for the Social Sciences).

4.1.2 Response rate

The majority of nurse managers available during the data collection period participated in the study. 275 nurse managers from nine hospitals participated in this study, which represented 86 per cent of the total nurse managers in these

hospitals. The others may have been on annual or maternity leave. Annual leave for nurse managers is 48 days per year, and it is therefore to be expected that more than 10 per cent of the staff are simultaneously on leave.

The following table shows the number of participants from each hospital.

Table 4. 2: Number of respondents as a percentage of total staff

Hospital Name	Total number of nurse managers	Total number of responses	Percentage of the responses
Royal Hospital	90	82	91
An Nahdah	25	22	88
Khoula	41	39	95
As Sultan Qaboos	34	19	55.8
Ibra	25	22	88
Sur	26	24	92.3
Sohar	30	24	80
Ar Rustaq	26	23	88.4
Ibri	24	20	83.3
Total	**321**	**275**	**85.6**
Excluded		4	.014
Net total		**271**	**84.4**

4.1.3 Demographic Information

Descriptive statistics such as frequencies and means were calculated for demographic information gathered in Section Three of the survey. The results were used to describe the participants' general characteristics.

The ages of the participants ranged from 25 to 60 years with a mean of 38.5 years and a standard deviation of 8.8 years (Figure 4.1). In Oman, as mentioned before, Omanis will replace non-Omanis in management posts, resulting in an increase in young, newly graduated Omanis in management posts. 219 female nurse managers made up 80.8 per cent of the 271 nurse managers who

participated in this study. 57.9 per cent of the participants were Omani, 22.5 Indian, 5.2 Philippino, 9.2 Jordanian and the rest were from other nationalities. These latter are not included in some analyses because, at three participants or fewer, they did not yield significant results. The percentage of Omani nurse managers participating in this study was similar to the total percentage of Omani nurses working in the Ministry of Health.

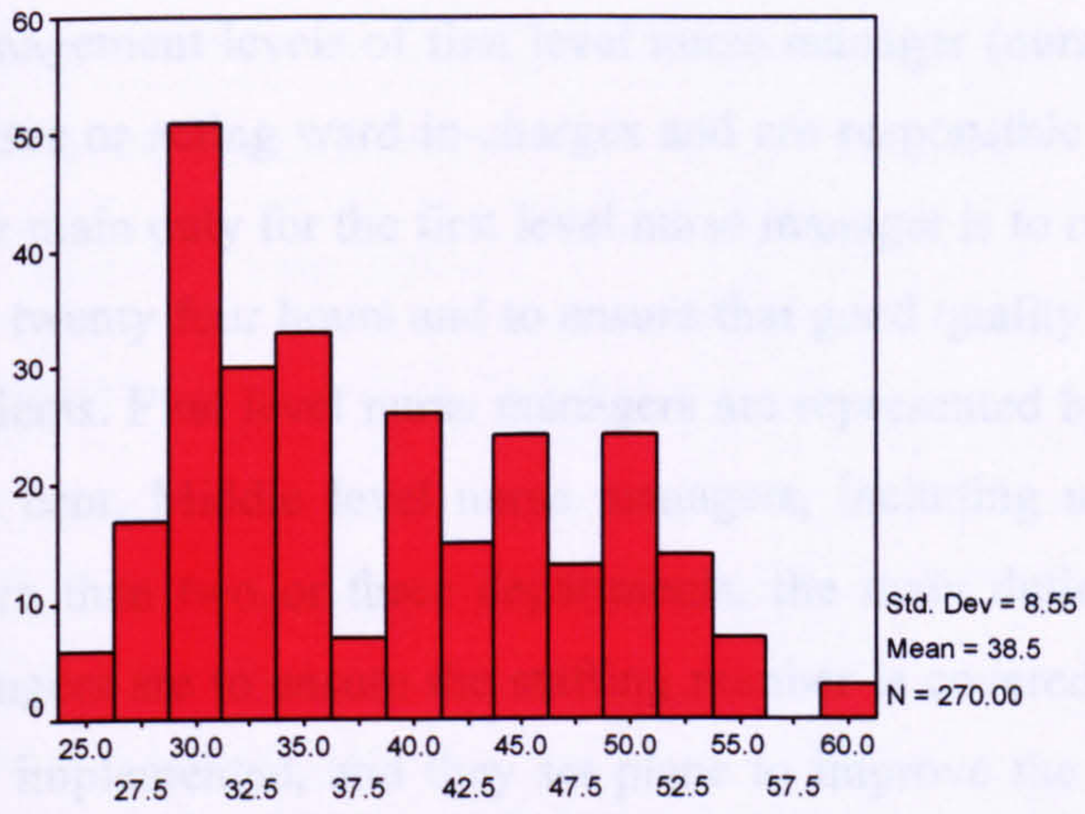

Figure 4.1: Distribution of the participants according to age

Table 4.3: Nationality of participants

Nationality	Frequency	Percentage
Omani	157	57.9
Indian	61	22.5
Philipino	14	5.2
Jordanian	25	9.2
British	3	1.1
South African	2	.7
Malaysian	3	1.1
Tanzanian	2	.7
Other Nationality	3	1.1
Total	**270**	**99.6**
Missing	1	.4
TOTAL	**271**	**100.0**

Table 4.4 shows the majority of the participants who are married

Table 4.4: Marital status of participants

Statues	Frequency	Percentage
Single	42	15.5
Married	215	79.3
Divorced	9	3.3
Widowed	5	1.8
Total	**271**	**100**

Table 4-5 shows the participants' current posts, summarised into the three management levels of first level nurse manager (nurses who work as in-charge nurses or acting ward in-charges and are responsible for one department only). The main duty for the first level nurse manager is to run his/her department over the twenty four hours and to ensure that good quality of care is providing to the patients. First level nurse managers are represented by 185 participants, or 68.3 per cent. Middle level nurse managers, including unit heads, responsible for more than two or three departments, the main duties for the unit head nurse mangers are to ensure the staffing number is covered and the standards of care are implemented, and they set plane to improve the quality of nursing acre in their unit. Hospital nursing supervisors are considers as Middle level nurse mangers, and they are responsible for the nursing department in the afternoon and at night. The Middle level nurse mangers make up 28.8 per cent of the participants. Top-level nursing manager (including the heads of nursing departments in each hospital), the head of nursing department is the key person and he/ she is the over all in charge about the nursing staff in the hospital. The top-level nurse managers form 3 per cent. Nine hospitals participated in the present research, but one head of nursing department in one of those hospitals did not answer the questions.

Table 4.5: Distribution of the sample according to management level

Post	Frequency	Percentage
First level nurse managers	185	68.3
Middle level nurse managers	78	28.8
Top level nurse managers	8	3.0
Total	**271**	**100.0**

More than half (54.2 per cent) of the participants had general diploma degrees in nursing 24 per cent had specialised diploma and general diplomas. 13.7 per cent had bachelor's degrees in nursing, 4.1 per cent also had bachelor degrees in nursing and specialised diplomas and 4.1 per cent had master's degrees in nursing.

Table 4.6: Participants' nursing qualifications

Nursing Qualification	Frequency	Percentage
General nursing diploma	147	54.2
Bachelor of science in nursing	37	13.7
General and specialised diploma	65	24.0
Bachelor in nursing and specialised diploma	11	4.1
Masters in nursing	11	4.1
Total	**271**	**100.0**

The years of experience as nurse manager ranged from 5 to 40 years, with a mean of 16.7 per cent and a standard deviation of 8.05 per cent. The mean for the years of experience as nurse manager is 7.2 years with a standard deviation 5.64 years and range from 1 year to 22.5 years. The mean for the years of experience in the current post is 4.17 per cent, with a standard deviation of 4.8 and a range from one to 20 years.

The following diagrams show years of experience as registered nurse; the tables break this down to each nursing level.

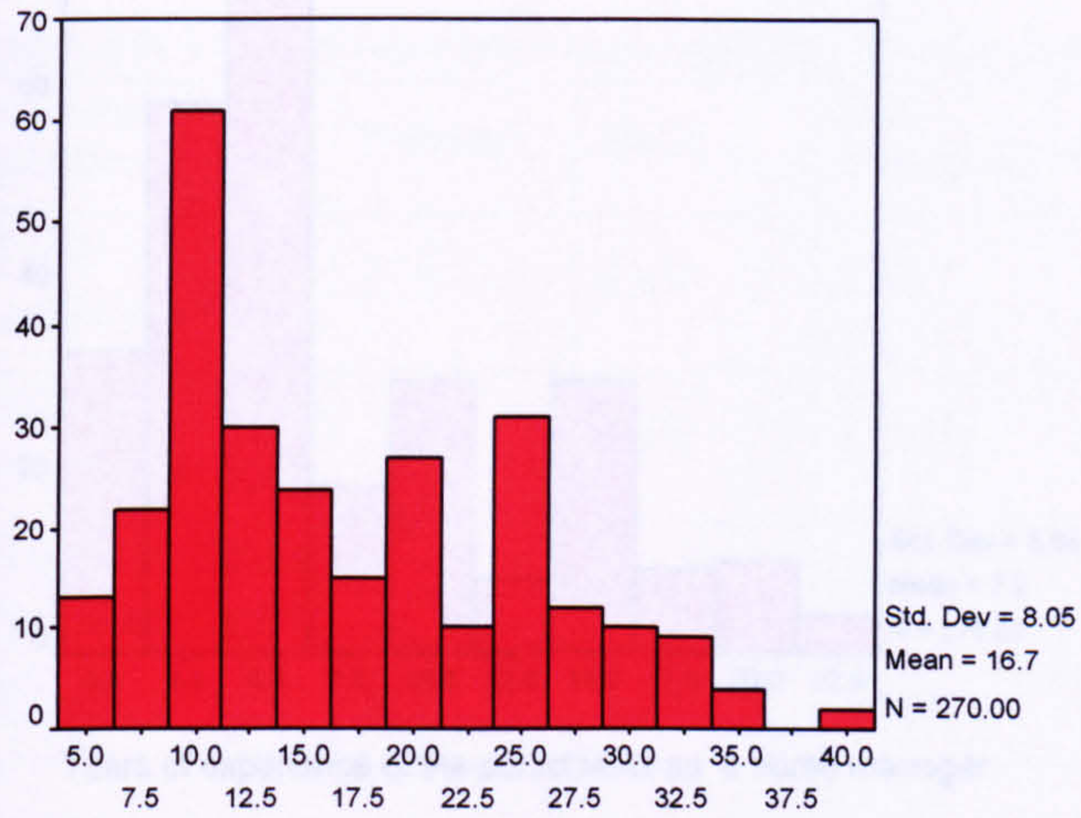

Figure 4.2: Participants' years of experience

Table 4.7: Years of experience as RN for each nursing management level

Current position	Number	Mean	Std. Deviation
First level nurse manager	185	15.45	7.168
Middle level nurse manager	77	18.97	9.169
Top level nurse manager	08	22.75	9.483
Total	**270**	**16.67**	**8.054**

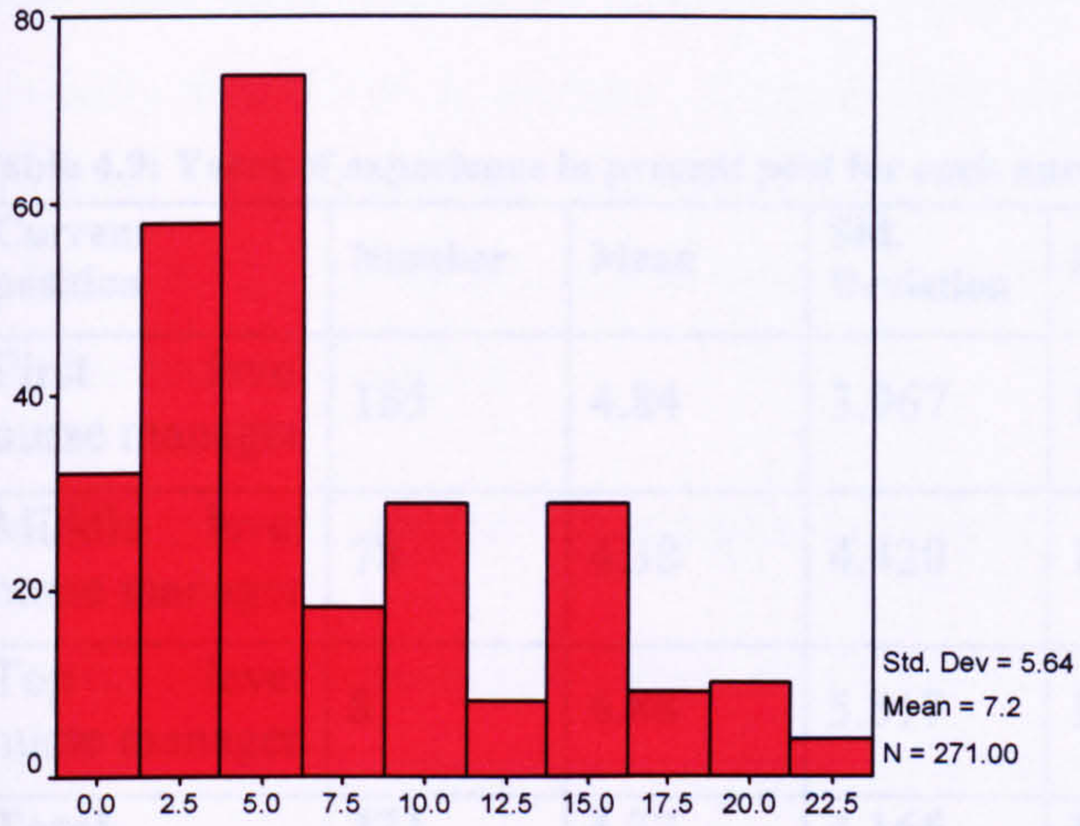

Figure 4.3: Participants' years of experience as nurse manager

Table 4.8: Years of experience as nurse manager for each nursing management level

Current position	Number	Mean	Std. Deviation
First level nurse manager	185	6.44	5.287
Middle level nurse manager	78	8.47	6.068
Top level nurse manager	8	10.75	6.319
Total	**271**	**7.15**	**5.641**

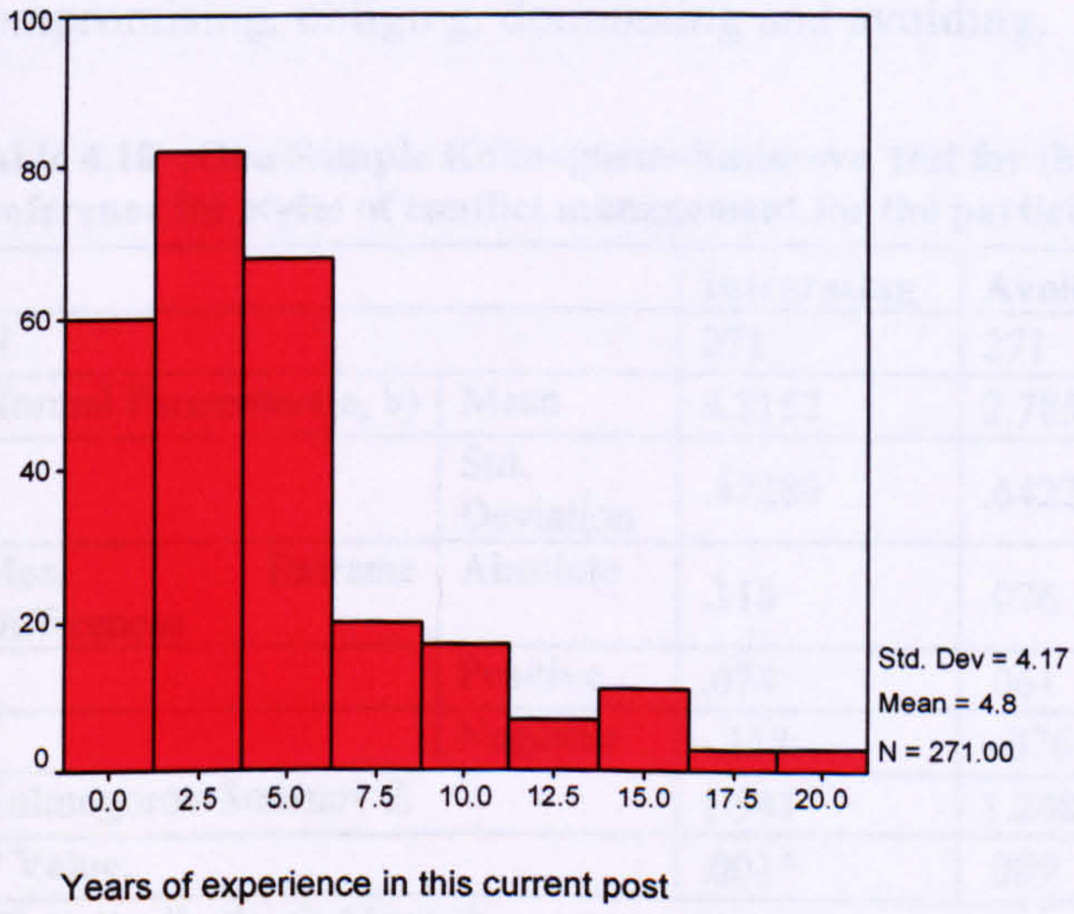

Figure 4.4: Participants' years of experience in current post

Table 4.9: Years of experience in present post for each nursing management level

Current position	Number	Mean	Std. Deviation	Minimum	Maximum
First level nurse manager	185	4.84	3.967	1	20
Middle level nurse manager	78	4.38	4.420	1	19
Top level nurse manager	8	6.88	5.817	1	16
Total	**271**	**4.77**	**4.165**	**1**	**20**

4.1.4 Conflict management styles used by nurse managers

To test whether the variables were normally distributed, the One-Sample Kolmogorov-Smimove test was employed. integrating and compromising are not normally distributed with *P*. (0.001 and 0.008). This test also gives the mean and standard deviation for the variables, and was therefore used to answer the first research question: What are the conflict management styles used by nurse managers in Sultanate of Oman? Table 4-10 shows the preference of styles used by the participants, with a preference for integrating followed in order by compromising, obliging, dominating and avoiding.

Table 4.10 :One-Sample Kolmogorov-Smimove test for the normal distribution and preference for styles of conflict management for the participants

		Integrating	Avoiding	Dominating	Obliging	Compromising
N		271	271	271	271	271
Normal Parameters(a, b)	Mean	4.3152	2.7859	2.9310	3.1485	3.4600
	Std. Deviation	.47289	.64222	.84732	.64555	.63468
Most Extreme Differences	Absolute	.118	.076	.067	.066	.101
	Positive	.074	.061	.067	.063	.068
	Negative	-.118	-.076	-.050	-.066	-.101
Kolmogorov-Smirnov Z		1.941	1.248	1.103	1.085	1.659
P Value.		.001*	.089	.175	.190	.008*

a Test distribution is Normal.
b Calculated from data.
* Significant α= 0.05, (2-tailed)

It is clear from the above table that integrating and compromising are not normally distributed. In addition, it can be seen table that integrating is the most favoured style of conflict management for nurse managers in Oman, with a mean of 4.31. This is followed in descending order by compromising, obliging, dominating and avoiding.

4.1.5 Age and conflict management styles

In many of the sections below there are five separate tests conducted on each of the five styles. For example here correlation is tested for each style against age. There is an increased possibility of Type I error with multiple testing. The researcher used Bonferonni inequality, which mean that the alpha level is divided by the number of tests (here 5 to make it 0 .01). While being a conservative approach, this reduction in the alpha level accounts for multiple tests in all the multiple testing below the revised alpha level is used.

To test the first hypothesis that there is no relationship between age and conflict management styles, Spearman's rho correlation test was used. The tests were designed to reveal any relationship between age and conflict management styles. There is a positive but not significant relationship between age and the integrating style. Likewise, the relationship between age and the avoiding and compromising styles is negative, but not significant. Unlike that between age and dominating and obliging style at P <.0.01 and P= .001 respectively. Hence hypothesis one is not supported and must be rejected because there is a definite relationship between nurse managers' ages and the conflict management styles they use. The results are shown in Table 4-11.

Table 4.11 :Relationship between age of participants and conflict management styles

			Age in years	Integrating	Avoiding	Dominating	Obliging	Compromising
Spearman's rho	Age in years	Correlation Coefficient	1.000	.103	-.065	-.328(**)	-.194(**)	-.046
		P value	.	.090	.286	<0.001	.001	.454
		N	270	270	270	270	270	270
	Integrating	Correlation Coefficient	.103	1.000	.034	-.086	.049	.270(**)
		P value	.090	.	.573	.157	.425	.<0.001
		N	270	271	271	271	271	271
	Avoiding	Correlation Coefficient	-.065	.034	1.000	.156(*)	.430(**)	.233(**)
		P value	.286	.573	.	.010	.<0.001	.<0.001
		N	270	271	271	271	271	271
	Dominating	Correlation Coefficient	-.328(**)	-.086	.156(*)	1.<0.001	.295(**)	.217(**)
		P value	.<0.001	.157	.010	.	.<0.001	.<0.001
		N	270	271	271	271	271	271
	Obliging	Correlation Coefficient	-.194(**)	.049	.430(**)	.295(**)	1.<0.001	.320(**)
		P value	.001	.425	.<0.001	.<0.001	.	.<0.001
		N	270	271	271	271	271	271
	Compromising	Correlation Coefficient	-.046	.270(**)	.233(**)	.217(**)	.320(**)	1.<0.001
		P value	.454	.<0.001	.<0.001	.<0.001	.<0.001	.
		N	270	271	271	271	271	271

** Correlation is significant at the 0.01 level (2-tailed).

- Correlation is significant at the 0.05 level (2-tailed).

4.1.6 Conflict management styles and years of experience as registered nurse

To test the second hypothesis, that there was no significant relationship between years of experience and conflict management styles, Spearman's test was used. The results (table 4.12) indicate there is a positive relationship between years of experience as a registered nurse and the integrating style. There is a negative relationship between years of experience as registered nurse and the other four styles. The relationship between years of experience and the styles of conflict management is significant, with obliging with $P< 0.001$ and dominating with P equal 0.001.

Table 4.12 :Relationship between years of experience and conflict management styles

			Years of experience as registered nurse	Integrating	Avoiding	Dominating	Obliging	Compromising
Spearman's rho	Years of experience as registered nurse	Correlation Coefficient	1.000	.100	-.064	-.326(**)	-.203(**)	-.048
		P value	.	.100	.293	.<0.001	.001	.428
		N	270	270	270	270	270	270
	Integrating	Correlation Coefficient	.100	1.000	.034	-.086	.049	.270(**)
		P value	.100	.	.573	.157	.425	.<0.001
		N	270	271	271	271	271	271
	Avoiding	Correlation Coefficient	-.064	.034	1.000	.156(*)	.430(**)	.233(**)
		P value	.293	.573	.	.010	.<0.001	.<0.001
		N	270	271	271	271	271	271
	Dominating	Correlation Coefficient	-.326(**)	-.086	.156(*)	1.<0.001	.295(**)	.217(**)
		P value	.<0.001	.157	.010	.	<0.001	<0.001
		N	270	271	271	271	271	271
	Obliging	Correlation Coefficient	-.203(**)	.049	.430(**)	.295(**)	1.<0.001	.320(**)
		P value	.001	.425	.<0.001	.<0.001	.	.<0.001
		N	270	271	271	271	271	271
	Compromising	Correlation Coefficient	-.048	.270(**)	.233(**)	.217(**)	.320(**)	1.000
		P value	.428	.<0.001	.<0.001	.<0.001	.<0.001	.
		N	270	271	271	271	271	271

** Correlation is significant at the 0.01 level (2-tailed)
- Correlation is significant at the 0.05 level (2-tailed)

Also, as in the previous two variables, years of experience as nurse manager (table 4.13) has the same relationship with conflict management styles: it is positive with the integrating style and negative with the other four. The relationship between years of experience as a nurse manager is significant, with the dominating style with *P* equalling 0.035, but this is not significant using the revised alpha level and even stronger with the obliging style with *P* equalling 0.005.

Table 4.13 :Relationship between years of experience as nurse manager and conflict management styles

			Years of experience as a nurse manager	Integrating	Avoiding	Dominating	Obliging	Compromising
Spearman's rho	Years of experience as a nurse manager	Correlation Coefficient	1.000	.069	-.112	-.126(*)	-.168(**)	-.007
		P value	.	.260	.067	.039	.005	.905
	Integrating	Correlation Coefficient	.069	1.000	.034	-.086	.049	.270(**)
		P value	.260	.	.573	.157	.425	.<0.001
	Avoiding	Correlation Coefficient	-.112	.034	1.000	.156(*)	.430(**)	.233(**)
		P value	.067	.573	.	.010	.<0.001	.<0.001
	Dominating	Correlation Coefficient	-.126(*)	-.086	.156(*)	1.000	.295(**)	.217(**)
		P value	.039	.157	.010	.	.<0.001	.<0.001
	Obliging	Correlation Coefficient	-.168(**)	.049	.430(**)	.295(**)	1.000	.320(**)
		P value	.005	.425	.<0.001	.<0.001	.	.<0.001
	Compromising	Correlation Coefficient	-.007	.270(**)	.233(**)	.217(**)	.320(**)	1.000
		P value	.905	.<0.001	.<0.001	.<0.001	.<0.001	.

Correlations(a)

* Correlation is significant at the 0.05 level (2-tailed).

** Correlation is significant at the 0.01 level (2-tailed).

a List wise N = 271

As seen in table 4.14 there is no relation between years of experience in the current post and integrating, while the relationship between this factor and compromising is positive but not significant. There are, likewise, negative but not significant relationships with avoiding, dominating and obliging. Therefore, the second hypothesis is supported.

Table 4.14 Relationship between years of experience in the current post and conflict management style

			Years of experience in current post	Integrating	Avoiding	Dominating	Obliging	Compromising
Spearman's rho	Years of experience in current post	Correlation Coefficient	1.000	.<0.001	-.130(*)	-.020	-.104	.032
		P value	.	1.000	.032	.748	.087	.601
	Integrating	Correlation Coefficient	.<0.001	1.000	.034	-.086	.049	.270(**)
		P value	1.000	.	.573	.157	.425	.<0.001
	Avoiding	Correlation Coefficient	-.130(*)	.034	1.000	.156(*)	.430(**)	.233(**)
		P value	.032	.573	.	.010	.<0.001	.<0.001
	Dominating	Correlation Coefficient	-.020	-.086	.156(*)	1.000	.295(**)	.217(**)
		P value	.748	.157	.010	.	.<0.001	.<0.001
	Obliging	Correlation Coefficient	-.104	.049	.430(**)	.295(**)	1.000	.320(**)
		P value	.087	.425	.<0.001	.<0.001	.	.<0.001
	Compromising	Correlation Coefficient	.032	.270(**)	.233(**)	.217(**)	.320(**)	1.000
		P value	.601	.<0.001	.<0.001	.<0.001	.<0.001	.

* Correlation is significant at the 0.05 level (2-tailed).
** Correlation is significant at the 0.01 level (2-tailed).
a List wise N = 271

4.1.7 Conflict management styles and gender

The Mann-Whitney test was used to test the third hypothesis, that there was no difference between male and female nurse managers in conflict management styles. Nurse managers do in fact appear to have different preferences according to gender. The next table shows these preferences.

Table 4.15: Gender and conflict management styles

Male	Female
Compromising	Avoiding
Dominating	Integrating
Obliging	Obliging
Integrating	Dominating
Avoiding	Compromising

Males favoured compromising, dominating, obliging, integrating and avoiding in that order. Females, on the other hand, preferred avoiding, integrating, obliging, dominating and compromising. This analysis reveals that the preferred styles are the direct reverse of each other for each gender. There is no significant difference between the mean for each style for both genders (table 4.16) except for compromising, where the mean for females is 161.51 and that for males is 129.94. The hypothesis was therefore not supported and was rejected: there is indeed a relationship between gender and conflict management styles.

Table 4.16: Preference of conflict management styles according to gender

	Gender	**N**	**Mean Rank**
Integrating	Female	219	137.13
	Male	52	131.24
	Total	**271**	
Avoiding	Female	219	138.64
	Male	52	124.87
	Total	**271**	
Dominating	Female	219	132.16
	Male	52	152.18
	Total	**271**	
Obliging	Female	219	134.68
	Male	52	141.56
	Total	**271**	
Compromising	Female	219	129.94
	Male	52	161.51
	Total	**271**	

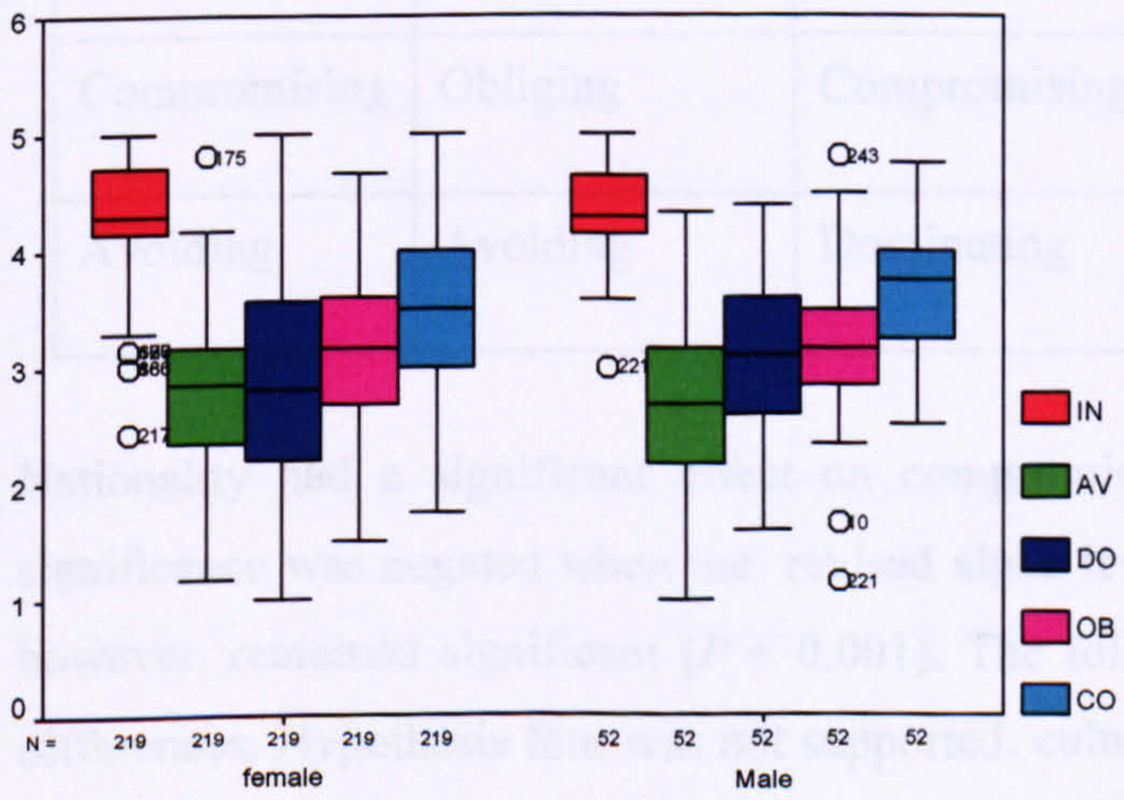

Figure 4.5: Gender and conflict management styles

4.1.8 Conflict management styles and nationality of the participants

The Kruskal Wallis test was used to test the fourth hypothesis, that there is no significant relationship between nationality and conflict management styles. The preference for each style of conflict management (ROCI-II) served as a separate dependent variable; culture (nationality) served as the independent variables. Nurse managers appear to have different styles according to their nationality. As seen in table 4.17 Omani managers preferred dominating, then compromising, while for Jordanian managers the situation was the opposite. Indian managers preferred avoiding, then obliging. Philipino managers preferred integrating then avoiding.

Table 4.17: Conflict management styles used by nurse managers according to nationality of the participants

Omani	**Jordanian**	**Indian**	**Philipino**
Dominating	Compromising	Avoiding	Integrating
Obliging	Dominating	Obliging	Avoiding
Integrating	Integrating	Integrating	Compromising
Compromising	Obliging	Compromising	Obliging
Avoiding	Avoiding	Dominating	Dominating

Nationality had a significant effect on compromising (P= 0.041) but this significance was negated when the revised alpha level was ued. Dominating, however, remained significant ($P < 0.001$). The following table shows these differences. Hypothesis four was not supported: culture does have an effect on conflict management styles.

Table 4.18 :Preference for conflict management styles according to nationality of the participants

Items	Nationality of the subject	N	Mean Rank
Integrating	Omani	157	132.47
	Indian	61	114.31
	Philipino	14	169.36
	Jordanian	25	120.46
	Total	257	---
Avoiding	Omani	157	125.03
	Indian	61	146.11
	Philipino	14	136.36
	Jordanian	25	108.04
	Total	257	---
Dominating	Omani	157	150.22
	Indian	61	78.31
	Philipino	14	83.46
	Jordanian	25	144.90
	Total	257	---
Obliging	Omani	157	136.80
	Indian	61	121.26
	Philipino	14	106.36
	Jordanian	25	111.60
	Total	257	----
Compromising	Omani	157	131.02
	Indian	61	112.64
	Philipino	14	119.18
	Jordanian	25	161.72
	Total	257	-----

Test Statistics (a,b)

	Integrating	Avoiding	Dominating	Obliging	Compromising
Chi-Square	7.259	5.842	47.752	5.086	8.277
Df	3	3	3	3	3
P Value	.064	.120	<.001*	.166	.041*

a Kruskal Wallis Test
b Grouping Variable: Nationality of the subject
* Significant α= 0.05 , (2-tailed)

There was a significant relationship of nationality for compromising and dominating with α =0.05

4.1.9 Conflict management styles and nursing qualification

The Kruskal Wallis test was again used to test the fifth hypothesis, that there was no significant relationship between nurse managers' nursing qualifications and their conflict management styles. Managers with Masters and Bachelors degrees in nursing with specialised diplomas preferred compromising. Diploma holders preferred dominating. Managers holding a Bachelors degree in

nursing preferred integrating. The following table shows the conflict management styles used by nurse managers according to their nursing qualifications.

Table 4.19: Nursing qualification and conflict management styles

Diploma	Diploma with higher diploma	BSN	BSN with diploma	Master
Obliging	Dominating	Integrating	Compromising	Compromising
Avoiding	Integrating	Avoiding	Integrating	Dominating
Dominating	Compromising	Compromising	Dominating	Integrating
Compromising	Obliging	Dominating	Avoiding	Avoiding
Integrating	Avoiding	Obliging	Obliging	Obliging

The analysis in the next table in fact shows a significant relationship. The significance for compromising is 0.019, obliging 0.003, dominating 0.006 and integrating 0.033.

Table 4.20 :Relationship between participants' nursing qualifications and conflict management style

Items	Nursing Education	N	Mean Rank
Integrating	General nursing diploma	147	122.98
	Bachelor of Science in nursing	37	148.47
	General and specialised diploma	65	153.80
	Bachelor in Nursing and specialised	11	168.86
	Masters in Nursing	11	129.95
	Total	**271**	
Avoiding	General nursing diploma	147	144.39
	Bachelor of Science in nursing	37	128.82
	General and specialised diploma	65	125.47
	Bachelor in Nursing and specialised	11	139.00
	Masters in nursing	11	107.23
	Total	**271**	
Dominating	General nursing diploma	147	134.41
	Bachelor of Science in nursing	37	98.82

Items	Nursing Education	N	Mean Rank
	General and specialised diploma	65	159.47
	Bachelor in Nursing and specialised	11	144.50
	Masters in nursing	11	135.14
	Total	**271**	
Obliging	General nursing diploma	147	149.41
	Bachelor of Science in nursing	37	97.34
	General and specialized diploma	65	134.75
	Bachelor in Nursing and specialized	11	130.64
	Masters in nursing	11	99.50
	Total	271	
Compromising	General nursing diploma	147	128.95
	Bachelor of Science in nursing	37	123.70
	General and specialised diploma	65	145.63
	Bachelor in Nursing and specialised	11	204.05
	Masters in nursing	11	146.64
	Total	**271**	

Test Statistics (a,b)

	Integrating	Avoiding	Dominating	Obliging	Compromising
Chi-Square	10.452	4.695	14.402	15.855	11.743
Df	4	4	4	4	4
P Value	.033*	.320	.006*	.003*	.019*

a Kruskal Wallis Test
b Grouping Variable: Nursing Education
* Significant α= 0.05 , (2-tailed)

These findings do not support the hypothesis: there is a significant relationship between nursing qualification and preferring conflict management style. Hypothesis five is therefore rejected.

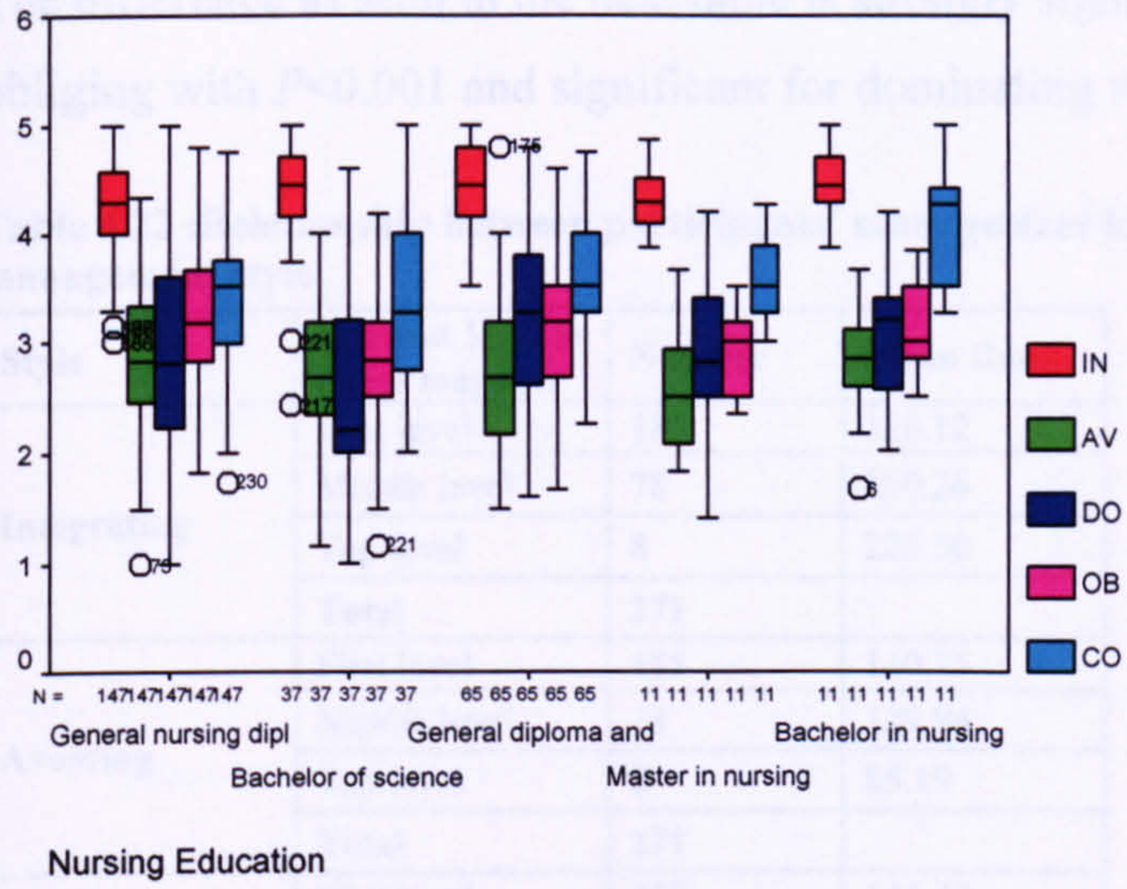

Figure 4.6: Conflict management styles and nursing education

4.1.10 Conflict management styles and nursing management level

The Kruskal Wallis test was also used to test the sixth hypothesis, that there is no significant relationship between the level of nursing management and conflict management styles. This hypothesis was rejected, since there is a significant difference in the preference of conflict management styles between nurse managers according to their management level. Obliging is the first choice for first level nurse managers and the last one for top-level managers, while integrating is given first preference by the latter and last by the former. Middle level managers prefer integrating, and use obliging as their last choice. The following table shows the conflict management styles used by nurse managers according to their nursing management levels.

Table 4.21: Nursing management level and conflict management styles

First level	Middle level	Top level
Obliging	Integrating	Integrating
Dominating	Avoiding	Compromising
Avoiding	Compromising	Dominating
Compromising	Dominating	Avoiding
Integrating	Obliging	Obliging

The difference as seen in the next table is strongly significant for integrating and obliging with $P<0.001$ and significant for dominating with $P=0.015$.

Table 4.22 :Relationship between participants' management levels and conflict management style

Style	Current level as nurse manager	Number	Mean Rank
Integrating	First level	185	126.12
	Middle level	78	150.26
	Top level	8	225.50
	Total	**271**	
Avoiding	First level	185	140.75
	Middle level	78	129.94
	Top level	8	85.19
	Total	**271**	
Dominating	First level	185	145.40
	Middle level	78	115.32
	Top level	8	120.31
	Total	**271**	
Obliging	First level	185	148.68
	Middle level	78	111.62
	Top level	8	80.50
	Total	**271**	
Compromising	First level	185	139.61
	Middle level	78	124.22
	Top level	8	167.31
	Total	**271**	

Test Statistics (a,b)

	Integrating	Avoiding	Dominating	Obliging	Compromising
Chi-Square	16.124	4.537	8.444	16.500	3.480
Df	2	2	2	2	2
P Value	<.001*	.103	.015*	<.001*	.176

a Kruskal Wallis Test
b Grouping Variable: Current position

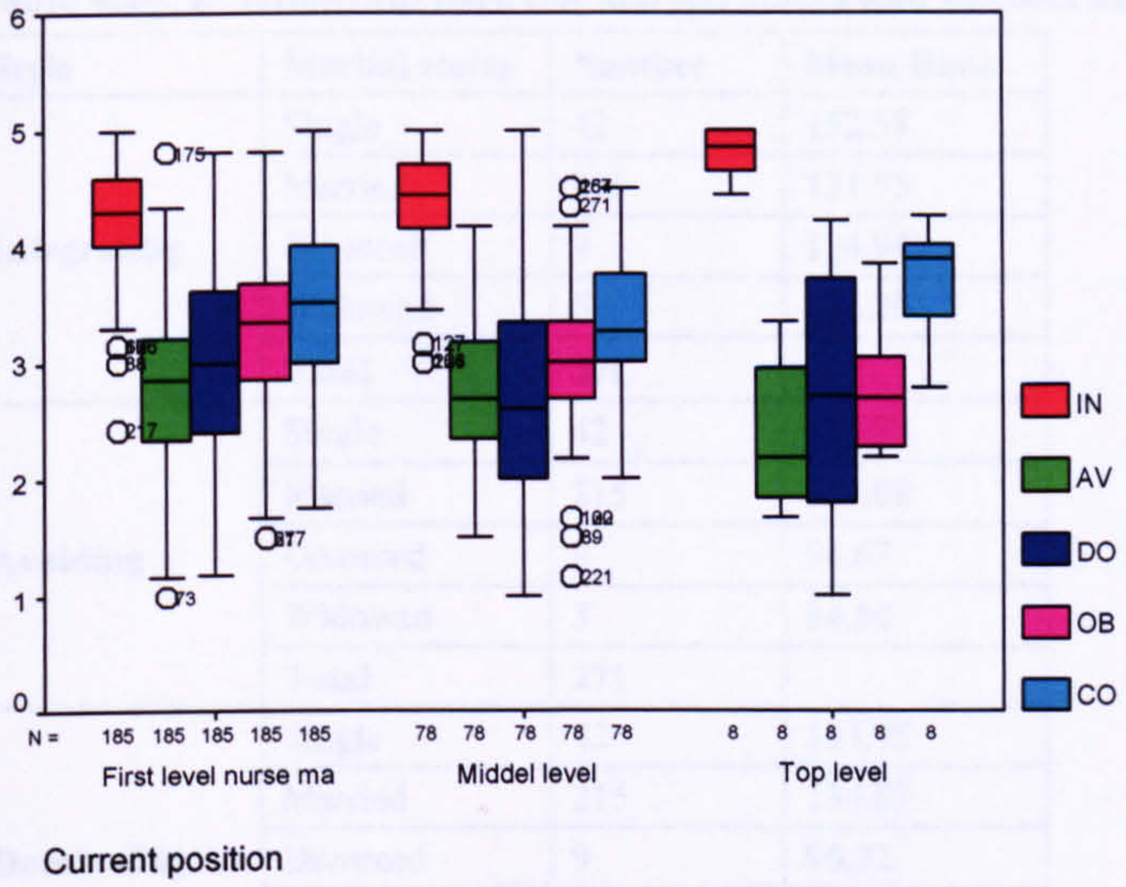

Figure 4.7: Conflict management styles and current position

4.1.12 Conflict management styles and marital status

Lastly, the Kruskal Wallis test was used for the seventh hypothesis, that there was no significant relationship between marital status and conflict management styles. This hypothesis was rejected because while there was a significant difference in the use of obliging at P=0.041, this is not significant according to the revised alpha level Widows and divorcees prefer integrating, and only use obliging where necessary. Single and married participants do not prefer specific styles. The hypothesis was nevertheless not supported and was therefore rejected. The next table shows the conflict management styles used by nurse managers according to their marital status.

Table 4.23: Marital status and conflict management styles

Single	Married	Divorce	Widow
Dominating	Avoiding	Integrating	Integrating
Integrating	Obliging	Compromising	Compromising
Compromising	Compromising	Dominating	Dominating
Obliging	Dominating	Avoiding	Avoiding
Avoiding	Integrating	Obliging	Obliging

Marital status had a significant effect on obliging, with P= 0.041 with α =0.05

Table 4.24: Relationship between marital status and conflict management style

Style	Marital status	Number	Mean Rank
Integrating	Single	42	152.58
	Married	215	131.75
	Divorced	9	134.94
	Widowed	5	181.20
	Total	**271**	
Avoiding	Single	42	135.23
	Married	215	139.08
	Divorced	9	94.67
	Widowed	5	84.50
	Total	**271**	
Dominating	Single	42	153.75
	Married	215	134.82
	Divorced	9	96.22
	Widowed	5	109.10
	Total	**271**	
Obliging	Single	42	145.08
	Married	215	137.80
	Divorced	9	93.50
	Widowed	5	58.70
	Total	**271**	
Compromising	Single	42	150.29
	Married	215	135.16
	Divorced	9	102.94
	Widowed	5	111.80
	Total	**271**	

Test Statistics (a, b)

	INTEGRATING	AVOIDING	DOMINATING	OBLIGING	COMPROMISING
Chi-Square	**4.220**	**5.028**	**5.131**	**8.235**	**3.548**
df	**3**	**3**	**3**	**3**	**3**
***P* value**	**.239**	**.170**	**.162**	**.041***	**.315**

a Kruskal Wallis Test
b Grouping Variable: Marital status

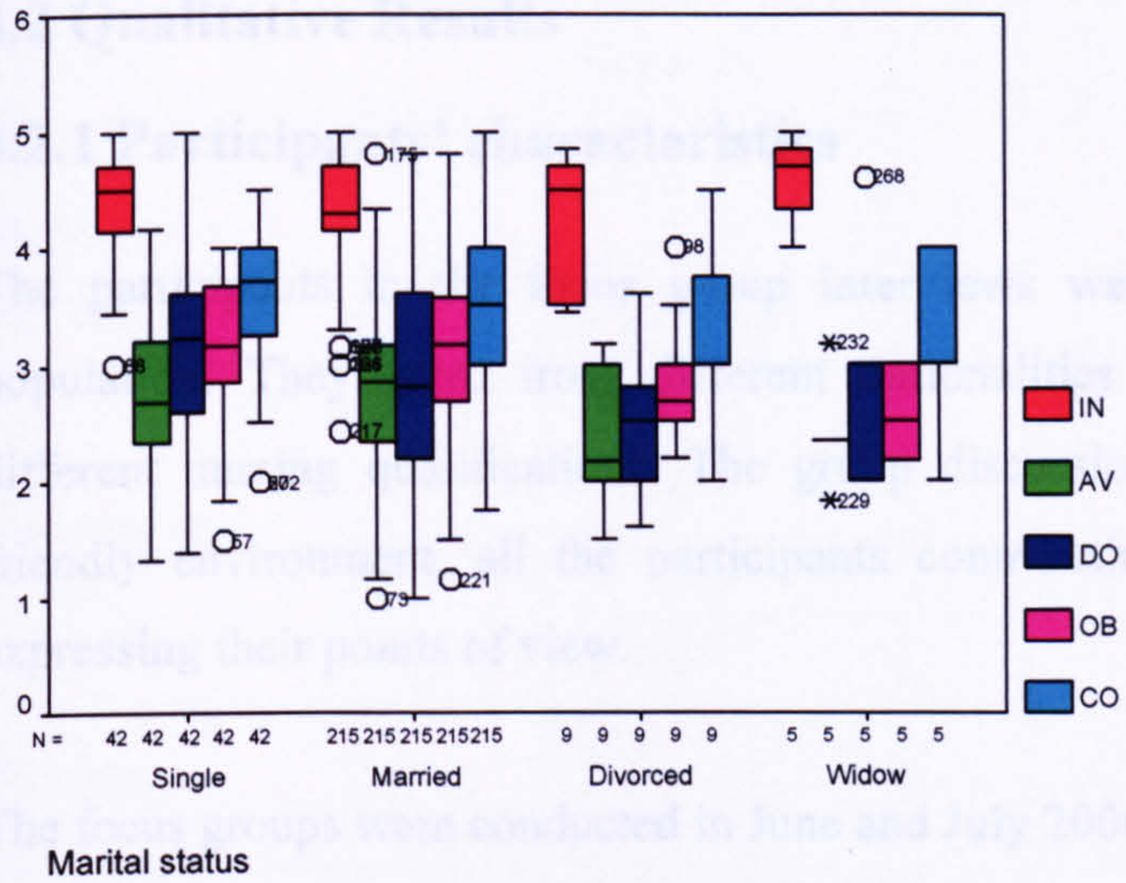

Figure 4.8: Conflict management styles and martial status

4.1.13 Summary of the quantitative results

1. There is a relationship between age and the conflict management styles used by nurse managers.
2. There is a relationship between years of experience as registered nurse, years of experience as nurse manager and years of experience in the current post on the one hand and conflict management styles on the other.
3. There is a relationship between gender and conflict management styles.
4. There is a relationship between culture and conflict management styles.
5. There is a relationship between nursing qualification and conflict management styles.
6. There is a relationship between the management level and conflict management styles.
7. There is relationship between marital status and conflict management styles.

As a conclusion, with more years of experience, qualifications and higher level of management, styles of integrating and compromising are more used than obliging, dominating and avoiding styles

4.2 Qualitative Results

4.2.1 Participants' characteristics

The participants in the focus group interviews were representative of the population. They were from different nationalities and positions and had different nursing qualifications. The group discussions were conducted in a friendly environment, all the participants contributing to the exchange and expressing their points of view.

The focus groups were conducted in June and July 2006. The first two were held at Hospital (A) and Hospital (B), and were each attended by eight first level nurse managers. The third group was held at Hospital (C) attended by four middle level nurse managers. From the analysis of the transcript, it can be seen that the groups agreed on all points. Three focus groups were sufficient; by the third one, the discussion was becoming repetitious and redundant. The next table summarises the demographical statistics of the participants in the focus groups.

Table 4.25 :Criteria of the focus group of the focus group interviews participants

Criteria	Parameter	Number
Total number of participants	20	
Age range	25-52 years	
Nationality	Omani	14
	Indian	4
	Jordanian	1
	Filipino	1
Gender	Female	14
	Male	6
Nursing Qualification	General nursing diploma	9
	Bachelor of Science in nursing	3
	General and specialised diploma	7
	Bachelor in nursing and specialised	1
Years of experience as registered nurse	5-35 years	20
Years of experience as nurse manager	1-20 years	20
Years of experience in current post	1-15 years	20
Current post	First level nurse manager	16
	Middle nurse manager	4

4.2.2 Focus group list of questions

4.2.2.1 Can you share an experience with us in your workplace leading to a conflict situation?

The following themes emerged from the participants answers for the first question. The full statements for all the focus group interviews can be seen in Appendix 4.

First Question themes:

- Nurse- doctor conflict.
- Conflict between nurses, and between nurses and administration and nurses and patients.
- No clear policy
- Conflict about resources
- Shortage of staff
- Communication
- Task conflict
- Administration interference
- Role conflict
- Lack of fairness

One common theme emerging from the groups was that conflict between nurses and doctors regarding patient treatment, nurse intervention or the nurse's role as patient advocate happened daily one nurse (A2) said "*One of my usual conflicts, I am doing it with my doctors that some times we are getting conflict*" .There was also conflict between doctors themselves, especially when they were required to see patients in other departments as mentioned by (A7) "*I have getting conflict between doctors the surgical doctors we are calling them to see one patient we call the second on call and he said to call the first on call and the first on call he will said to call our interns*". Doctors were sometimes not fully oriented to the treatment protocol or to the policy, and this caused conflict involving nurses, either between doctors or between patients and their families, (B4) said "*We have conflict in our department like patient and nurse conflict. We have different kind of view between patients and nurse especially. I am working in A/E in triaging when we tell our patient any thing and they don't agree with us or they got another kind of view this can lead to argument and lead to conflict*". Shortage of staff and lack of resources emerged as constant sources of conflict. The participants maintained that shortage of staff is a common problem in all departments, as a result of which some staff work seven continuous night duties, placing them under severe pressure one nurse (C3) "*mentioned we have shortage of staff. We have face a conflict I left with few*

nurse and some of them are with sick leave". Nurses were unhappy with this situation, and this led to conflict with nurse managers. Shortage of staff led in some cases to burnout, and nurses asked for transfers or even resigned. Communication between members of the health team and between nurses and patients was seen as another source of conflict for most first level nurse managers, (A1) mentioned "*Some time I have conflict with my top manager in the hospital regarding the communication if there is some of the communication gap*" . A conflict of roles between those of nurse manager and housewife caused problems for some female nurse managers. Interference by administration, unclear policies and lack of fairness caused conflict for the majority of nurse managers. In one case, two staff members attended one workshop; one of them received remuneration over and above his allowance, while the other received nothing because his managers did not like him.

Table 4.26: Source of conflict for nurse managers

- Lack of administrative fairness
- Shortage of staff
- High staff turnover
- Shortage of equipment
- Communication (unclear, absent altogether or impolite)
- Unclear policy
- Difference in culture
- Nurses' or doctors' knowledge deficit

4.2.2.2 How do you address a situation when you are confronted with conflict in your organisation?

The next themes emerged from the findings of the second question in the focus group interviews.

Second Question themes:

1- Effect on the quality of patient care
2- Complaint to top management
3- Communication problems

4- Effect on work flow

5- Staff ask for team changes

6- Increase in sick leave, absence and burnout

7- Voices raised in serious argument

8- Objectives not achieved

The second question in the focus group interviews regarding addressing conflict situations. In summary, the groups' conclusion was that most nurse managers do not have any method of recognising incipient conflict within the team. The problems are only recognised when they reached a certain point nurse (B 3) mentioned "*conflict could be not seen as a conflict but it causing some destruction work for example*" . Deterioration in the quality of care is a sign of conflict within the department, as is a large number of staff asking to change their work or shift patterns (A 5 mentioned " *we can address the conflict if we feel there is a breakdown or the quality of care break down so that the conflict started between all the staff*". Some managers said that they discovered conflict between their staff during meetings from signs such as the raised voices of participants and the meeting ending without achieving set objectives one nurse (C3) mentioned "*in the meeting and we have an objective for the meeting and if we not meet the objective completely and the people raises voices in a huge argument and always keep player and we try to bring every one back to the objective of the meeting and the people start a point thing about that which we don't actually not carry out our meeting normally*".

4.2.2.3 How did you handle the situation to resolve or manage the conflict?

Third Question themes:

1- Problem-solving strategies

2- Report conflict to a higher authority

3- Encourage communication

4- Use alternative solutions

5- Pressurise the parties to work together

6- Need for counselling

7- Solutions depend on the type of conflict

8- Ignore the conflict

9- A negative response is possible

10- Firmness is necessary

The third question facing the focus groups was how situations were handled to manage conflict. The answers to this question showed that there was confusion in the minds of some managers between the leadership and conflict management styles one nurse mentioned "*I think I prefer to be a situational leadership according to what I handle I will change. If you putting the person into a risk definitely your conflict management or leadership management will definitely change according to the situation I am handling. Some are urgent and some can wait and some you can form committee and has to decide by your own because you are the only senior available there and you have to decide this is right and this is wrong, this is white and this is black according to the situation you are handling* (B4). Handling of conflict situations depended on the set of circumstances. Selection of conflict management styles depended on the individual situation, which obviously changed from one instance to another. If the problem does not affect the patient and if it is not serious, it will be ignored. If the conflict is between staff members, they try to listen to both parties and solve the problem between them by discussion and by finding an acceptable solution. Improving communication amongst the team and encouraging staff to talk to each other is another method used by nurse managers. Some stated that they sometimes become firm and use an autocratic management style if the conflict affects work, one nurse mentioned "*it is according to the situation because each situation handling in different management we will not be dealing with all the problem in the same style. If you have problem between two staff and both of them are staff you will deal in different than if the problem between patient and staff*" (B3), and other nurse (C3) mentioned *"it is depend on he type of the conflict some of conflict it is just need to ignore it and it will solve by itself*". Sometimes nurse managers at both levels forward the problem to a higher authority. Three non-Omani managers said their styles of conflict management and even general management changed after they started work in Oman: they became cold and long-suffering in order to fit in with staff culture

one non Omani nurse said "*I changed my management styles, when I come to Oman I came very very patient because I am not Arabic speaking and its important to me to really understand what is the people are really meaning*" (C1),. All participants said that conflict management styles depended on who the other party was. If they were managers they will ignore the problem. One participant said that they could not contradict their supervisor, while another found no difficulty in doing so, even though she was her matron

4.2.2.4 In what way have your conflict management styles changed or made effective as result of the conflict's management?

Fourth Question themes:

1- The conflict situation
2- Level of conflict
3- Position of the person involved
4- Type of conflict
5- Level of the involvement in the conflict
6- It depends on the culture of the other party
7- Selection of the style which enables a win-win result

The answers to this question show agreement between all participants that the conflict management styles depend on the individual circumstances. Some situations needed much involvement and some should have been ignored. If this style was used at one point and it proved ineffective, it would be changed the next time "*we change the conflict management styles according to the problem or according to the situation*" (A5) Said, and (A6) added "*I feel the conflict management styles should be according to the situation and some time we can use more than one style to solve one conflict". And in the other group " B3" agreed and she mentioned "with them it is according to the situation because each situation handling in different management we will not be dealing with all the problem in the same style*" also the middle nurse managers mentioned the same point when (C1) said "*absolutely here I used different conflict management styles some times in some situation you need to be very firm, some*

you need to be apologize" In addition, conflict management styles depend on the differences in gender, position and qualification of the parties, (C4) said "*some time you have two identical situations but the people who involved is different so we have different styles*". Attitudes towards subordinates will tended to be firm and unyielding, but would be apologetic and dismissive if faced with supervisors (C3) said "*yes either we like this or not. In this level the culture factors interfere. Certainly I will not go to say to my matron this is the way if you like do it or leave because I will not achieve what I plan to achieve by approaching her to give me solution for the conflict. If I used this style with my matron it will not be effective and I will lose all thing instead of solve the conflict and I will create more conflict but the people who are let me say the subordinate it will different and if I talk to my colleague also I will use different. Because here the politic play part diplomacy will ply a part in it and you must come to negotiation*". One participant said that they must be respectful in conflict situations with their boss, not because he is the boss but because he is older, and in their familial culture they are taught to respect older people (C3) mentioned "*like example if I meet with our director general beside his authority as director general I must respect his age, certain things I cant say to him not because he is a director general, no but because he is at a age of my father*".

. Formulating committees to solve the conflict and start discussion is another way to manage conflict if the situation is not urgent. One participant said if the other party were educated, they would change their conflict management styles because the other party will understand them more than an uneducated person would

4.2.2.5 How do you feel about the relationship between conflict management and issues such as age, gender, background and education? What role does it play in managing the conflict situation?

Fifth Question themes:

1- Education and experience play a role in conflict management styles.
2- Age plays a role in conflict management, but to a lesse extent than other variables.

3- There is a significant relationship between gender and conflict management style.
4- Culture is an important variable in conflict management style.

The results of these discussions revealed agreement that gender does play a role in conflict management styles. Some participants refer this to cultural attitudes towards females. One participant said that some patients even refused to listen to her because she was a female. Participants did not perceive an inherent difference between the sexes, but rather viewed genders as being treated differently on cultural grounds. Some participants mentioned that males also become involved in conflict more than females; according to one participant, their capacity to deal with conflict is greater than that of females. In addition, some participants said that their styles would change according to the gender of the other party (A1) said," *Gender was naturally and culturally there. In relationships, in conflict management or solving problems, female in the culture are always weaker than males and males are above females*".

Age plays a role in conflict management styles, but it is less important than the other factors. According to the participants, people would show more respect towards someone older than them. One participant gave an example of her brother and her relative: one was older, but the other one was more mature. Other participants said that age is important if it is accompanied by experience; otherwise, age had no role to play.

Educational background was an important factor for all participants. According to them, more highly educated people learn more and will be more aware of conflict management styles. Some participants mentioned that they have diploma degrees in nursing only, and were not taught about conflict management styles; they recommended involving conflict management styles in the diploma programme. Some participants ranked education as the most significant factor in conflict management styles "*Education is very vital in these issues. If you give the person the scientific way of solving the problem he will have knowledge of how to deal with conflict in the future and at the same time*

how to manage" (A1), while others mentioned that conflict with another party was more easily solved if that party was educated.

Experience was another variable with a significant relationship with conflict management styles. Participants saw the experience of being exposed to conflict situations as conferring the ability to develop individual conflict management styles and the wisdom to choose which to apply in any given situation. Some regretted that they had become nurse managers without proper preparation and without enough experience, rendering them weak in conflict management, and indeed in management in general, *"(C2), "I think by age you can solve the problem because you will know you have the experience and you learning from your situation what is not managing well. Whenever you growing up and rising up the managerial scale, I think you become more senior." Another in the second focus group (B3) added, "It is almost the same experience playing a big role in solving the conflict. In each day you have different problems; the person who doesn't have enough experience definitely will not be able to solve the problem which experience would help him to solve".*

Culture is another variable with a significant relationship with conflict management styles. Omani nurse managers said that their culture affected them in conflict situations (C4) mentioned ": *In our culture, you must respect the person who is older than you are even if they are wrong and some time this effect in our decision and affect the work . (C3)said "In our culture you must respect your father, your senior, any body older, do not speak if any body speaking, female don't interfere with male part*" Non-Omani nurse managers said that culture creates conflict and affects conflict management styles (B7) said" *I am coming from India. Our culture is totally different and how we solve the problems is different from this part of the world. If I don't know the culture and I am in a conflict situation and I am trying to solve the problem it is going to be hell so I will not put my nose in if I don't know the culture. Culture does play a role and I must know about it and it is very important that we must know the culture*". One nurse said that when she first started, she touched patients for therapeutic reasons, whereas in Oman females are not allowed to touch males.

One manager said that the culture in Oman is different from that in their country. When they started in Oman they had many insoluble problems with their staff, leading them to change their management style to become cold in their behaviour in order to adapt to this culture, (B7 and C1) said, "*here I change my conflict management style*"..

From the themes mentioned the researcher reached the following conclusions from the focus group interviews.

4-2.3 Main themes for the focus group interviews:

1- The nurse managers who participated in the focus group perceived the presence of interpersonal, interprofessional conflict in their daily work.

2- Deficiency in communication affected the quality of nursing care and was a sign of conflict in the department.

3- Nurse managers use all styles of conflict management in handling conflict.

4- The selection of conflict management style depended on the situation, the other party's position and the type of the conflict.

5- Age, gender, experience, culture, management level and nursing qualification played a role in conflict management styles.

4.2.4 Summary

1. Conflict is part of nurse managers' daily life. The sources of conflict for the nurse managers are summarised in table 5-6.

2. Nurse managers in Oman have no method of diagnosing conflict situations before the signs of conflict start to appear.

3. Nurse managers have no training regarding conflict and conflict management styles. There is a knowledge deficit among nurse managers regarding conflict management.

4. The nurse managers in Oman do change the nature and selection of their conflict management styles depending on the situation, the other party and the type of conflict.

5. Culture, age, gender, nursing qualification and years of experience play a role in conflict management styles.
6. Non-Omani nurse managers used different conflict management styles in Oman from those they would be in their own countries

Chapter Five: Discussion

5.1 Introduction

Conflict is an inevitable phenomenon in organisations. It may contribute to personal frustrations, but it can also benefit those organisations (Rahim, 2002). Conflict among nurses has been identified as a significant issue within health care settings around the world (Almost 2006). The styles of conflict management used by nurse managers can greatly influence the outcome of such conflicts. To reap the full benefits of organisational conflict involving people from different teams, genders and cultures, an understanding of the way members of each team handle conflict, as well as evaluate others in conflict situations, is essential.

The aim of this study was to explore the conflict management styles used by nurse managers in the Sultanate of Oman. This study also took into consideration other factors that can affect conflict management styles. These factors include, but are not limited to, gender, nationality, age, nursing education, years of experience, marital status and management level. They were included in the analysis in order to determine their relationships to the conflict management styles used by nurse managers. The researcher employed both quantitative and qualitative methods in order to provide a more complete understanding of conflict issues and how nurse managers dealt with them. This chapter discusses the results and places them in the context of the literature and the research questions. Furthermore, limitations, recommendations will be discussed, and a conclusion then given.

5.2 Styles of conflict management used by nurse managers in Sultanate of Oman

Five common approaches or styles for conflict management have been identified within the literature: dominating, avoiding, obliging, compromising and integrating (Blake and Mouton 1964; Thomas 1976; Rahim 1983). The choice of appropriate conflict- handling mechanisms in daily decision-making is one of many challenges facing nurse managers, a choice which is influenced by the individual and environment in which he or she works. Managing conflict effectively promotes an environment that stimulates personal growth and assists in providing quality patient care (Barton, 1991).

The aim of this study is to explore the conflict management styles used by nurse managers in Sultanate of Oman. From the research findings it appears that nurse managers in Oman overall and within the various subcategories use all five conflict management styles. It is to be expected that each person does not use one style but several, depending on the situation. However, the distribution for the sample differs from that of the reference group in other disciplines and from the nursing group in other countries. However, it is similar to Qatan's (2001) findings conducted in the same country but in the education field. There are also group differences within the subcategories of nurse managers, such as differences in gender, age, nationality and management level.

The results of the present study suggest that nurse managers use all styles of conflict management in conflict situations. The mean for each style ranges from 4.3 for integrating to 2.78 for avoiding, which means that nurse managers use all conflict management styles to manage the conflict situation. This result was supported by the literature, which maintains that no one style is appropriate for all conflict situations. Rahim (1986) suggests that all styles of conflict management are appropriate in one situation or another. In addition, Vivar (2006) suggests that there is no appropriate or inappropriate strategy to deal with conflict. The time available, context, culture and type of personality should be taken into account. Barton (1991) mentions that each of the conflict handling

strategies can be used effectively depending on the process and on structural factors that come into play. Nurse managers in Oman move from one conflict management style to another, selecting the appropriate one depending on the situation, type of problem, people involved, is important to the other party, and potential effect on patient care. One participant (C4) said "*the solutions depend on the type of the problem and the people involved*". Another participant in the same focus group, (C1) mentioned that she changes her conflict management style according to the variables: "*here I used different conflict management styles. Sometimes in some situations you need to be very firm, in some you need to be apologetic, sometimes or most of the time you need to be very fair or democratic*". It also depends on the other party:" *It is depend on the player as well. Like for example sometimes you have two identical situations but the people involved are different so we have different styles*", (C4) said.

The results of this study suggest that the nurse managers tended to used integrating as their first choice of conflict management style, followed by compromising, obliging, dominating and avoiding. These results differ from all previous researches on conflict management styles used by nurses (summary table 2-2). Integrating was not selected as the first choice in any previous study. These findings are similar to Qatan's (2001) regarding conflict management styles used by secondary school principals in Oman.

The results of the present study suggest that nurse managers tend to choose a conflict management mode involving a form of the integrating (win-win) or problem solving approach. Integrating, also referred to as problem solving, is considered one of the more effective ways of handling conflict to achieve long-term benefit (Thomas 1976; Marriner 1982; Rahim 1986 and; Marriner 1995. Integrating or collaborating is a preferred style, because it is one in which both parties win and concerns are explored in an environment of openness and equality. In nursing studies integrating is found to be the second most frequently used in three studies conducted on managers either on the clinical side or the academic side (Woodtli (1987) in her study regarding conflict management styles used by deans of nursing, Barton (1991) in her study regarding the nurse

managers in different levels in United States, and Hendel et al. 2005) in their study regarding the conflict management styles used by nurse managers in five general hospitals in Israel. Integrating was also found to be the fourth most frequently used by nurse managers in the US in Cavanagh's (1988) study. Needless to say, the nursing environment is a different entity than corporations and government agencies. The two environments have different purposes that may respectively be characterised as a concern for production and a concern for people, primarily patients. Nurses work in teams for periods of 24 hours. Nurses work with each other over long periods; managers have opportunity to work closely with subordinates and peers, giving them the chance to understand each other and to discuss problems and find solutions. Most nurse managers in Oman are in staff nurse posts, taking the role of ward in charge because of the Omanisation process and the shortage of senior staff. Because of this, they feel that they have no power over their team; they still consider themselves as staff nurses assigned to facilitate work. Nurse managers like to maintain good relationships with their subordinates, as a result of which they can convince the administration to designate them as nurse manager.

Valentine (1995) relates the underuse of collaboration by American nurses to the perceived power differences between nurses and other health care workers. In Oman's hospitals power is shared equally between nurses and doctors because the majority of doctors working in hospitals (72 per cent) are expatriates and the majority of nurse managers are Omani. Consequently, each has power, the one professional and the other national. This forms the basis for collaboration between nurses and doctors. The nurse managers in Oman appear to use the integrating style with their colleagues rather than their supervisors. One nurse manager mentioned *"Maybe your colleague, the other nursing officer, understands what you need but maybe the matron will not understand what is going on" (C2)*. Also, (B4) said "*we work into collaboration in the win-win the solution at the end of the day"*. There is no age gap among nurse managers and between them and their subordinates, especially with first level nurse managers, which facilitates discussion and encourages them to use the compromising style.

The Arabic language is full of verbal behaviour: Observers of Arab culture have argued that Arab society is an expressive verbal society, characterised by an emotional responsiveness to language (Ajami, 1981; Almaney, 1981). The rich Arabic language provides an ideal means for extended discussion and debate, which is usually carried out with emotional intensity. As Almaney (1981, p.12) has observed, " a foreigner may think an Arab, from the manner of speaking, to be excited, angry or affectionate when in fact he is not".

Compromising is the second most preferred style used by nurse managers, with a mean of 3.46. This style is in a lose-lose mode. For compromising, both parties must be willing to give up something of equal value. In previous research regarding nursing, compromising is the first choice for the participants according to Woodtli, 1987; Barton, 1991; and Hendel et al, 2005, and the second choice according to Cavanagh, 1988, 1991; and Kunaviktikul et al., 2000. Compromising is a quick fix for the temporary settlement of complex issues, for inconsequential issues, when goals are important but not worth major disruption, and for backup when collaboration and competition fail (Valentine, 2001). This approach focuses on quick, mutually agreeable decisions that partially satisfy both parties (Rahim, 1983).It is expected that nurse managers use this style, since it indicates a focus mainly on the practical aspects of care. Nurse managers' perceptions of the hierarchy may influence their use of compromising as a way to manage conflict. Nurse managers in Oman are positioned between traditional administrative decision makers, mainly male, and subordinate workers, staff nurses who are mainly women. Valentine (2001) shows that compromising is used often because consensus is a group goal that takes precedence over individual and institutional goals. It seems the nurse managers in Oman use compromising with their peers. This style is most prevalent when two parties have relatively equal power (Rahim 1983, 1986). Kozan's (1989) survey shows that Jordanian managers use mainly compromising with peers, and Lee (2002) demonstrates the same results regarding Korean managers.

Obliging is the third most frequent style used by nurses in Oman. In this style one party neglects their own concern to satisfy those of the other. This style is used in routine work and when the issue important to other party (Valentine, 2001). Obliging is the first choice for staff nurses in Kunaviktikul's (2000) study, the second for the staff nurse sample in Cavanagh (1991) and the nurse managers in Eason's (1999) study, the third for nurse managers in Cavanagh (1988, 1991), the fourth for the dean of nursing schools in Woodtli (1987) and the last for nurse managers in Hendel et al's (2005) study. Nurse managers in Oman, especially those at the first level, and non-Omanis feel that they are not secure in their position, and because of this they use the obliging style with the administration in order to secure their place. As mentioned by Marriner (1982), obliging promotes harmony and gains credits that can be used at a later stage.

Dominating is the fourth style used by nurse managers in Oman. In this style one party neglects the other's concerns. This style is appropriate to protect the patient's life and to avoid putting someone else in danger (McElhaney 1996, Vivar 2006). In previous nursing research, dominating was reported to be the third most preferred style by Hendel et al's (2005) participants and the last used by those of Woodtli, (1987; Cavanagh, (1988, 1991); Barton, (1991); Eason, (1999); and Kunaviktikul et al (2000). Nurse managers would naturally use dominating, especially during their daily work in order to manage emergencies. It seems that nurse managers in Oman use dominating if the conflict will adversely affect work. One nurse manager in the third group said "It *depends on the conflict: if it is going to cause problems and stop or block work you must be autocratic in style*". In addition, another participant said "*if the conflict affects patient care no need to wait to repeat it, so you have to take solution or procedure for that*" (A4). Also, as Omani culture maintains a relatively wide distance in power between various levels, it is to be expected that supervisors use dominating with their subordinates. One nurse manager in the third focus group mentioned *"if you are my subordinate I will use the autocrat style - no, it depends on the other party*". Kozan (1989) found that employees were more accommodating to ward supervisors, more avoiding toward peers, and more forcing towards subordinate.

Avoiding was the least favourite style used by nurse managers in Oman. Avoiding results from low self-esteem and high concern for others. Previous nursing research shows that avoiding is the first choice for Cavanagh's, (1988, 1991) and Eason's, (1999) subjects and the third for Woodtli's, (1987), Barton's (1991) and Kunaviktikul's, (2000), and the fourth for Hendel's, (2005). In Oman some nurse managers, especially at the first level, feel powerless, and therefore they use avoiding, especially with their supervisors. In addition, they use this style if the topic is not important and will not affect the work environment. One nurse manager in the third focus group said, *"Some of conflict should just be ignored and it will solve itself"*

Report to authority and use of third parties

The participants in the focus groups mentioned they reported to higher administration as a style of conflict management. Qatan's (2001) participants also used reporting to a higher authority as the fifth preferred style and Dmour's (2004) participants as the third; both of these studies were conducted in Arab countries. The managers reported to the administration if they did not have the solution to the problem or if they needed to maintain face with the other party. Participant (A) said, *"We are trying to work to the direct person who causes this conflict so if we can solve within that closed area (I mean department) we solve. But in case it can't be solved other reasons, we to other people who can solve it. Also if not solved, we can report it to higher authority"*. Moreover (A8) said, *"The in-charge has the role to solve this problem and talk with them but if there is no response then we can raise it to the head of the department"*. In collectivistic cultures, third party roles are significant for two interrelated reasons. Firstly, disputes are seen as a collective problem - that is, of the group, organisation or community, rather than a problem concerning the two parties alone. Secondly, intermediaries help maintain harmony through face-saving (Wall and Blum 1991). According to Ting-Toomey et al. (1991), members of collectivistic cultures are concerned not only with "saving face," but also with "giving face." While face-saving concerns lead to direct face-negotiation strategies and confrontational styles, face-giving concerns lead to indirect face-

negotiation strategies. Using a third party is one way to avoid direct confrontation with another. This is because a direct communication approach in a conflict situation may create embarrassing results for the other party and disrupt harmony. On the other hand, parties may communicate negative feelings more easily through intermediaries whose function is sometimes to soften those feelings and present them in terms that are more acceptable or within the context of underlying concerns and difficulties.

5.3 Attitudes toward conflict

Although not considered in any of the research questions, the participants' narrations reflected their attitudes toward conflict, which provided a better understanding of their perspectives. Conflict is pervasive. It can be functional or dysfunctional. Simple disagreement is not a conflict. Nurse managers perceive conflict as having positive as well as negative outcomes that can be quite unexpected.

According to Thomas (1992) conflict is `the process that begins when one party perceives that the other party has negatively affected, or is about to negatively affect, some thing that he or she cares about` (p. 653). In his view, conflict is an undesirable phenomenon that has a negative effect. Nevertheless, as previously mentioned, conflict should not be solely regarded as dysfunctional. Far from it: conflict is also constructive, as it can be a catalyst for new ideas, progress, positive change and growth (Rahim, 1986; White, 1998; and Vivar, 2006). Participants in the focus groups considered conflict as constructive as well as detrimental. One participant in the first focus group (A2) said "*Conflict between the in charge and the staff is the management I mean the cases to prioritise the care which is coming in order and how we can detected. This cause "good" conflict leads to improve the quality of care*". This view fits with Rahim's (1986), White's (1998) and Vivar's (2006) view as stated above. Indeed, conflict increases creativity and innovation, provides more energy and motivation, offers people the opportunity for personal growth and healthier

relationships, encourages self-examination and fosters reappraisal of the situation. The participants benefited from conflict by building their knowledge and skills and strengthening their relationships with other team members.

5.4 Sources of conflict for nurse managers in Sultanate of Oman

Although not considered in any of the research questions, but the participants in the focus groups emphases on the sources of conflict happened for them in their daily work. All managers in the three focus groups provided a wide range of actual sources of conflict. Nurse managers deal with internal and external conflict daily as their work required a high level of skill and the necessity to work as a team in a variety of situations, as well as having a 24-hour responsibility for the delivery of care. Nurse manager interviewees mentioned the professional relationship between nurse and doctor as a source of conflict. This is not unique for nurses in Oman. Inter-professional conflicts between medicine and nursing have been documented since the time of Florence Nightingale (Kalisch and Kalisch 1977). Nurse managers attributes their conflict with doctors to the patient treatment plan. Participant (A8) said, *"What we note is that some doctors are not aware of the ABG parameter the normal range".* One manager refers this conflict to the differece in the role between the nurse and doctor. One nurse in-group two (B7) said, *"When the nurses try to advocate for the patient, the doctors don't like it because of the ego problem".* Lack of clear policy in dealing with patients, whether in the admission stage or when being transferred to other departments or other hospitals is another source of conflict. Conflict between nurses and doctors is now expected in all hospitals, because whereas nurses formerly operated in compliance with doctors' instructions, they have begun to reject the traditional paradigm of doctor dominance and nurse deference. As a result, nurses have acquired greater responsibility for decision-making (Katzman, 1989). Porter-O'Grady (2004) refers this conflict to the differences in information, values and beliefs, experience, roles, interests and goals. In Oman, the majority of nurses and nurse managers have only diploma degrees in nursing, while the doctors have at least bachelor degrees in medicine. This differences in education level causes conflict, a finding supported by Tengilimoglu and Kisa (2005) when they

mentioned that educational differences among the hospital staff were a major barrier to good communication and information flow between groups. This is reinforced by French et al (2000) and McVicar (2003) when they identify conflict with physicians as the main source of workplace stress on nurses.

Communication is another source of conflict for nurse managers, who report poor communication between them and top management, doctors and other health team members, patients and other nurses either in the same or in another team. The managers identified the nature of these problems: there is either no or unclear communication. Communication problems within the nursing environment is to be expected, and may in fact be greater than in any other environment because nurses work as part of the health care team, which might be culturally diverse. Kozan (1988) finds that people from similar cultural backgrounds tend to work together well primarily due to their shared cultural understanding and consequently of conflict behaviour, among other factors. In addition, the differences in the age is high and all these factors create the miscommunication. In addition, nursing turnover is high in Oman especially in the last five years (MOH 2006) – new nurses join teams daily. Any team will create its own style of communication, and when new members join it they will need time to adapt to this style; during this process, there will inevitably be much miscommunication. In Oman's hospitals there are frequent changes in administration, and the absence of clear and consistent policies and work standards create communication problems. Communication is mentioned in the literature as a source of conflict in all organisations. According to Warner (2001) one source of conflict frequently mentioned by nurses is the style of communication, whether verbal or non-verbal, and its lack. Also, hospitals have a diversity of players in the delivery of health care services, with different educational levels and personalities between health team members, which will naturally cause communication problems. Communication is also mentioned as a source of conflict by Gardner, (1992); Lemieux-Charles, (1994); Callister, (1995); Kunaviktikul, (2000); Porter-O'Grady, (2004); Hendel et al., (2005), and Tengilimoglu and Kisa, (2005).

Working in a different culture is one source of conflict for non-Omani nurse managers. Oman is an Arabic Muslim country with its own specific culture, and nurses recruited to work in Oman require time to adapt. One participant (C1) said, *"If I work with my colleague and I want to greet him I can't touch him or shake hands. When you move from culture to different culture it needs from you a lot of adjustment and you should learn about the new culture"*. This source of conflict is also mentioned by YU XU and Davidhizar (2004) who found that conflict frequently arises when people from different cultures are required to work as a group or a team.

Shortages of resources, either human or material, are another source of conflict for nurse managers. Shortages of equipment will affect the quality of care and create problems for the nursing staff and nurse managers. One participant (A4) said *"the in-charge of the general pharmacy does not give us enough indent for what our department needs, and this caused problem with the patients"*. Such shortages affect the quality of patient care. Shortages in human resources, both in quantity and quality, are one of the most frequent sources of conflict for all Omani nurse managers. The health care system in Oman depends on expatriate nurses, which makes them feel insecure because of the Omanisation process. They therefore try to find work in another country, and resign when they are offered another job. Foreign nurses leaving Oman take with them long years of experience; they are replaced by newly graduated Omani nurses. In Oman, there is no national regulatory mechanism for determining standards of nursing practice in areas such as knowledge, skills, experience and application, or for obtaining minimum competencies which graduating nurses should have achieved. When nurses complete basic nursing, they become registered nurses simply by having completed the course of study. Newly graduated nurses have to fulfil internship requirements; otherwise, they not permitted to practice. This is the only criteria for newly graduate nurses to start work. After a while, departments are left with few nurses, some of them without experience. This shortage leads to work overload for nurses and results in burnout. One manager (C3) said "*We have faced a conflict. I am left with few nurses, and some of them are on sick leave. The nurses work seven nights and get seven off and they have to be called. They shut*

their GSM off because she is expected at any moment." (C4) *"This leads to sick leave, asking to be transferred out, absence from work".* This finding is supported by Kunaviktikul et al (2000) and McVicar (2003), who discovered limited staff resources in those units resulting in higher levels of stress. Conflict appears to be a part of nurses' daily lives, and the optimal goal of each nurse manager in conflict management is to create a win-win solution for all involved.

5.5 Culture and conflict management styles

It appears that nurse managers of all nationalities use the five styles, but nationality has a significant effect on two styles of conflict management: compromising, where $P= 0.041$ and dominating, where $P< 0.001$. Four nationalities were included in the analysis because the others nationalities are not well presented in the sample. The preference of conflict management style is different for each nationality. The results are represented in Table (5-2).

Hofstede (2001) in his study of cultural consequences combined all the Arab countries and dealt with them as one country with the same culture. Oman and Jordan are Arab countries sharing the same culture, language and religion. The culture in each country is considered as a subculture of the main Arab one. This research shows that nurse managers from each of the two nationalities had different stylistic preferences. The findings of this study make a reasonable case for the effect of subcultures on conflict management style. Subculture, as defined by values, was as strong in predicting styles as organisational size and respondent age and gender. These findings extend Hofstede's (2001) argument that national culture influences organisational behaviour. Like differences in national cultures, differences among subcultures of the same country significantly influence conflict behaviour in organisations.

This research is not supported by previous studies conducted in both countries. This difference can be related to the fact that the population for the previous study conducted in Oman was from the field of education, where the environment and the job are different from those of nursing. The previous studies in Jordan were also conducted in the field of educational within Jordan

itself, while the Jordanians participating in the present study work outside their country. While Omani nurse managers prefer dominating and obliging, Jordanian ones prefer compromising and dominating. This relates to many factors. Most Omanis occupy the post of nurse manager without being designated for that post; they therefore tend to dominate their subordinates to control the department, and use obliging with the administration and their supervisors in order to secure their positions. This pattern reflects the authoritarian tone of administration in Oman, and the role of collectivism in suppressing competition among peers. Moreover, frank conversation is not easy in a society with high power differentials. Under such conditions, people are always careful about what they say and how they say it. In addition, Kozan and Ergin (1999) maintain that individuals who use the controlling style were stronger in power values. Their style could be indicative of a desire to accommodate their peers and supervisors in order to secure positions in the company. In Oman, as mentioned earlier, Omani staff nurses are promoted to the role of nurse manager without preparation or any extra training or education, so they to control the department by dominating their subordinates while obliging their supervisors. One Omani nurse manager (C3) said "*if I meet with our director general, besides his authority as director general I must respect his age. There are certain things I can't say to him, not because he is a director general, but because he is my father's age*". In Arab culture, the individual must pay respect to family elders and defend the family. The elders, in return, are expected to settle disputes. Growing up in a strong family-oriented culture is an emotionally rich and satisfying experience. Children receive attention from parents and other family members and spend much time with them. Individuals are therefore deeply embedded in their in-groups, and their individual identities are defined in the context of their groups. As a result, there is a cost attached to the support received from the in-group. The individual has to be careful not to disappoint the other members and to satisfy the others' expectations. In the context of nursing, supervisors have to maintain good relationships and to keep the post for them.

The Jordanian nurse managers recruited to Oman are on a higher scale grade and receive the highest salary of all the nurses. Most if not all of them have many years of experience and at least a bachelor's degree in nursing. The Jordanian nurse managers are working on Oman focusing in improving the nursing care and plan to stay a long time, and therefore use compromising as preferred style. Kozan, (1989) found Jordanian managers are mainly compromising with peers. Valentine (2001) pointed out frequent use of compromising indicates a focus mainly on practical aspect of care.

Integrating is the third preferred conflict management style used by Omani and Jordanian nurse managers. This finding is not supported by the literature; all previous studies conducted in both countries find this style to be the participants' favourite (Al Bawab 1986, Qatan 2001, Al Belbeisi 2003, Harem 2003, Dmour 2004). This difference relates mostly to the fact that the previous research was conducted in the field of education, in which the participants did not have to deal with emergencies and life and death situations, giving them time for negotiation and discussion to reach agreement and solve the problem. It seems that nurse managers use integrating if there is a relationship or personal conflict not related to work or not affecting a patient's life and quality of nursing care. One participant in the first focus group (A4) said, *"If it small we can talk verbally to solve the problem. If there is no change we have to change our styles. We can change"*.

Compromising is the fourth style used by Omani nurse managers, while it is the second choice for Qatan's (2001) participants. But in both studies compromising comes directly after integrating. Compromising is used as a backup for dominating.

Indian and Philipino nurse managers use different conflict management styles from Jordanian and Omani ones. Filipinos seem to prefer integrating, which is to be expected given that they have earned a reputation for having good work ethics, being persistent and good team players, always following direction, having excellent clinical skills and rarely complaining (Yu Xu and Davidhizar

2004). Avoiding is the first and obliging is the second choice for Indian nurse managers, while avoiding is the second choice for the Filipino nurse managers and obliging is their fourth preference. The majority of Indian nurse managers were recruited to Oman as staff nurses, and after many years of experience they were promoted to work as nurse managers. Some of them still have the designation of staff nurse, and therefore they use obliging with their managers and avoiding with their peers.Indian and Filipino nurse managers are highly concerned for the other. Valentine (2001) referred the frequent use of the avoiding style to the sense of powerlessness associated with the nurse manager's role. Furthermore, a high concern for others is most likely to occur when there is an expectation of a long-term dependency on the other party. This finding is supported by the literature. Yu Xu and Davidhizar (2004) state that Asian nurses (including Philippinos and Indians), who have a primarily communal mentality, tend to use avoiding, obliging and integrating to maintain interpersonal harmony. Asians are socialised into respecting authority, whether it be household heads, community leaders or managers and administrators in the workplace (Valentine ,2001). Ting-Toomey et al (2000) noted that Latino and Asian Americans tend to use obliging and avoiding. Latino and Asian American cultures do not perceive these styles as negative, argue the authors, who continue that obliging and avoiding are not understood identically in all cultures; Asians, unlike those from Western cultures, do not view obliging and avoiding adversely. Compromising is the fourth conflict style preferred by Indians and the third by Philippinos. It seems they use this style with subordinates in non-emergencies. Dominating is the last choice of Indian and Filipino nurse managers, as well as for the participants in the studies by Woodtli (1987, Cavanagh (1988, 1991), Barton (1991), Eason (1999)and Kunaviktikul (2000). Less use of the dominating style is related to less power; nurse managers feel that they do not have the power to use this style because most Indian nurse managers do not have the designation of nurse manager. Both Indians and Filipinos feel that they are in Oman temporally and that Omani nurses will perhaps take over their roles at any time; they also have the traditional view of nurses as being inferior to doctors.

Thus, culture does play a role in determining a person's choice of conflict resolution strategy. One participant in the second focus group (B7) said" *I am coming from India. Our culture is totally different and how we solve the problems is different from this part of the world. If I don't know the culture and I am in a conflict situation and I am trying to solve the problem it is going to be hell so I will not put my nose in if I don't know the culture. Culture does play a role and I must know about it and it is very important that we must know the culture*".

Despite the extant literature on strategies of conflict resolution, most studies investigating the effects of culture and personality do so separately. To date, most of the work examining the impact of culture on conflict resolution styles has been done using the standard cultural variables of individualism–collectivism, power distance, masculinity– femininity, and short term-long term orientation as outlined by Hofstede (1983). But in this research four nationalities are considered as collectivist and the conflict management styles are measured by the tools developed in Western culture. There is no evidence regarding the understanding of the same term and no research as to whether or not each nationality uses the same style in their country. Two non-Omani nurse managers (B7 and C1) said, "*Here I change my conflict management style*". More studies need to be carried out to find if the same styles are used by nurse managers in their own country, and yet others are needed to determine whether the same styles are used in other countries.

5.6 Gender and conflict management

This part of the study focuses on whether males and females prefer different styles of conflict management when dealing with conflict. The findings show that gender may influence a nurse manager's choice of conflict management style. Findings relating to gender and preferences for conflict behaviour have to date been inconsistent. Some studies have produced evidence supporting such gender stereotypes, as females rely more on harmony-enhancing choices of style, preferring avoiding as their first choice (Cavanagh 1988, Cavanagh 1991, Eason 1999, Valentine 2001). However, there is other evidence showing no

significant differences attributable to gender regarding preferences for particular conflict styles (e.g. Ting-Toomey, Oetzel and Yee). Woodtli (1987) and Hendel et al (2005) found that females used compromising as their first choice of style. Other researchers have found that women use a cooperative style more than their male counterparts (Levine & Feldman 1997). Research conducted in Arab countries also have different finding. Qatan (2001) found the Omani males used avoidance more than females; this was the only difference. Al-Bawab (2001) also found that female Jordanian principals were more compromising and less obliging than their male counterparts, while gender had no effect in the other studies (Harem 2003, Belbeisi 2003 , Dmour 2004). In this study, female nurse managers using avoiding as a preferred conflict management styles, as do the participants in the studies by Cavanagh (1988 and 1991), Eason (1999) and Valentine (2001). While male managers used compromising as their first choice, for females it was the last.

Viewed from the perspective of gender, the process by which women are socialised encourages them to build relationships and to bring people together, not to drive them apart. Women are generally culturally trained to be more concerned with interpersonal aspects of relationships than are men, often subordinating their own interests, preferences and needs to those of others. Generally speaking, it is believed that cooperativeness is more characteristic of women and assertiveness is more representative of the traits that men possess and it is not surprising to find that the female participants in this study preferred avoiding followed by collaboration, and the male nurse managers preferred compromising followed by integrating.

Female nurses tend to view handling conflict as a way to seek affirmation and support while also attempting to maintain harmony (Valentine 2001). Because nurse managers work in contexts in which they are unlikely to occupy the most powerful positions, the choice of conflict management styles may, in part, be based on the powerlessness associated with those positions. Women have been accustomed to depend on others in order to meet their emotional needs, and to value support; conflict is seen as a distancing behaviour that may result in

rejection. The participants in the focus groups related the differences in conflict management style between male and female to culture. One participant in the first focus group (A1) said, *"Gender was naturally and culturally there. In relationships, in conflict management or solving problems, female in the culture are always weaker than males and males are above females"*. Women in Oman valuing caring; in addition, they must respect men, and therefore they cannot negotiate with them. When they try, the community gives them negative feedback. This was supported by one participant in the first focus group (A2), who stated, *"The nature of the female is not like the male. Males are always fitting but female always like to be safe from that fighting"*. In Oman, the community considers the male always right in a conflict with a female. One participant in the first focus group said (A4), *" I think there is some habit of gender. She like to submit the problem to him. He likes to say I am the right and he is wrong. This habit with the people"*.

5.7 Nursing education and conflict management

This study found that nursing education has an effect on conflict management styles. There is a significant difference between compromising .019, obliging .003 dominating .006 and integrating .033. Research regarding the effect of educational level on preferences for conflict management styles has been inconsistent: while Qatan (2001), Dmour (2004) and Handle et al (2005) find no significant role for educational level in the choice of such styles, Harem (2003) discerns a relationship between educational level and the dominating and avoiding styles. The participants in the focus group agreed on the importance of education in conflict management. One participant in first focus group (A1) said, *"Education is very vital in these issues. If you give the person the scientific way of solving the problem he will have knowledge of how to deal with conflict in the future and at the same time how to manage"*. A participant in second focus group (B6) said *"Education gives the main guidelines. Experiencing something is very different when you deal with a conflict situation because without education you cannot go forward"*. Nurse managers holding a diploma degree in nursing preferred obliging and avoiding because they felt powerless.

The participants believe that knowledge confers power. A participant in second focus group (B4) said "*If you have knowledge you have power*". This belief made possessors merely of diploma degrees feel powerless because they had no university or specialised degree. Those with diploma degrees are in nursing management posts without the appropriate designation, and hence they try to oblige their supervisors and avoiding conflict because they have no knowledge of conflict management styles. The specialised nursing diploma is a one year study, and nursing management is one of the specialised diplomas offered in Oman. Students are taught conflict management strategies during this course. When such student obtains specialised diplomas they will be nurses in charge for the relevant departments, secure in their management positions and more knowledgeable than other people in the department. The majority of nurses with bachelor degrees participating in this study were non-Omani and there is a role for nationality in the selection of conflict management style. The Omani nurse managers with masters degrees graduated from United States, and in addition to their possession of qualifications which are consider the highest in the nursing profession in Oman, they are now also in the top nursing posts.

5.8 Management level and conflict management styles

It seems that nurse managers in the three-management levels used all the conflict management styles but in different sequences. There is a significant difference between the integrating, dominating and obliging styles. Previous research reveals divergent findings regarding the effect of management levels on the selection of conflict management styles. While Chusmir and Mills (1989) find no effect, Barton (1991) find that assistant heads of nursing use avoiding more than the other two management levels, and that nurse administrators use competing as their second choice while assistant heads and heads of nursing use it last. Harem (2003) finds that department heads (first level) use the avoiding more than did administrators. First level nurse managers use the obliging and dominating as their first two choices, which may be due to the fact that their entry-level management position places them in the role of subordinate more frequently than the other two management groups. This means that they tend to oblige their supervisors and dominate their subordinates. The participants in the

focus groups explained this. One participants in the second group (B8) said, "*Subordinates are the ones who guide them, but if your supervisor is more experienced and she is the supervisor you have to tell her no but in a diplomatic way*". The primary role of middle level nurse managers (unit heads and hospital nursing supervisors) is to facilitate the work, and it is therefore expected that they select the integrating style as first choice, and to use avoiding if the problem does not affect the workflow. One nurse manager in the third focus group (C3) said, "*The way I treat it, it depends on the type of the conflict. Some conflict should just be ignored and it will solve itself.* The same nurse manager also added regarding his conflict with the nurse, "*My personal role in the conflict as a middle level manager who will solve this conflict is that I need to identify and to bring to this nurses. My role is to carry out orders to the highest level of satisfaction I can*". The top-level nurse managers have managerial positions in nursing departments and they report to the chief executive officer. It is therefore expected that they use the integrating style with subordinates from the nursing staff to let the work run. At the same time they use compromising with the administration. From the present researcher's experience, when the administration asks them to move nurses they ask some return for nursing. For example they will agree to transfer a particular nurse to the lab or x-ray if they are given one medical orderly.

5.9 Marital status and conflict management styles

The effect of the marital status on the obliging style is clear. Previous research has found no effect for this factor on conflict management styles. Married nurses – especially women – who constituted the majority in this study preferred avoiding and obliging. Because nurses are primarily women, they are busy and have a large amount of responsibility at home, so they try to avoid conflict at work so as to not affect them at home. One married participant in the first focus group (A7) supported this explanation by stating" *I face problems with my family, so I have changed the styles of management totally now, and I am trying to change my work according to my position. I will do my work. If it not my work I will not do it, but I will assign other staff to do it*". She is obviously trying to avoid conflict at work and keep herself as stress-free as possible by

assigning other nurses to do some work. When conflict starts, it affects her relationship with her family.

5.10 Age and years of experience

There is a negative relationship between age and years of experience as registered nurse on the one hand and the obliging and dominating styles on the other. Previous nursing research has found no effect for age on conflict management styles, although Harem (2003) finds a negative relationship between avoiding and age and a positive one between dominating and age. Ceting and Hacifazhoglu (2004) find a positive relationship between age and integrating. Age is a very important source of respect in traditional Arab society, and provides legitimacy and credibility for intervention in social conflict, regardless of the nature of the dispute (Abu-Nimer 1996). In Arab countries, the age of the person is the one source of respect regardless of their educational level or role in the organisation. One nurse in the second focus group (B4) confirmed this statement: "*My mother at home is not educated and always at the end of the day we go to her and ask her advice and solution*". Some participant's link age and experience: one stated in the third focus group (C2), "*I think by age you can solve the problem because you will know you have the experience and you learning from your situation what is not managing well. Whenever you growing up and rising up the managerial scale, I think you become more senior.*" Another in the second focus group (B3) added, *"It is almost the same experience playing a big role in solving the conflict. In each day you have different problems; the person who doesn't have enough experience definitely will not be able to solve the problem which experience would help him to solve".*

A negative relation was found between experience in the current post and avoiding styles. In the previous research Handel et al (2005) find that the longer nurse managers were in position, the more they used collaboration. The negative relationship between avoiding and experience in the current post relates to the effect of bad conflict management in the departments' outcomes. The longer

nurses stay in position the less they can avoid daily conflict, because a conflict avoided will reappear and will eventually affect work. They therefore know that they must try to manage the conflict directly rather than avoiding it.

5.11 Limitations, recommendations and conclusion

5.11.1 Limitations

Many factors can influence the findings of a study such as this, even when the maximum effort is made to reduce unnecessary effects and the greatest care in study design is taken. These limitations should be taken into consideration in future research. The limitations of this study are:

Data Collection and Samples

The samples are of nurse managers from different nationalities. Some nationalities are represented by small numbers and judgments on the populations of those countries cannot be made from these samples. Therefore the results must be generalised with caution. Also, no previous study was conducted to explore conflict management styles for nurses in Oman in order to compare the two samples and to find if management has any effect on conflict management styles.

Self-Reports

Both the quantitative and the qualitative methods used in this study rely on self-reports, the objectivity of which can be affected by the attitudes of the respondents. They may wish to present themselves to the researchers and to the others in the focus groups interviews in a socially desirable, positive light; they may feel the need to provide "politically correct" answers; or (with particular reference to the present case of conflict management) their responses may simply reflect their own self-image and their views of others, as individuals and

according to their hierarchical positions. Such factors may distort the accuracy of their self-reporting regarding their own behaviour and that of others

Instruments

Some of the words used in the instruments may have been inappropriate to the Omani cultural context, either because they were inadequate to that context, or even because they expressed ideas that did not exist in it. The reverse applies too, of course: English words may not capture Omani cultural concepts. One relevant example is that the conflict style instrument might not express the conflict management styles appropriate to cultures, Omani and foreign, whose representatives participated in this study. This limitation was ameliorated by the researcher's ability to explain any ambiguities in person and to respond immediately to any new concepts employed by nurse managers.

The other obvious difficulties were language-related. It could not be taken for granted that nurse managers working in Oman would have fully understood questions in English. Again, the effect of this was minimised by the pilot study of twenty staff nurses, who confirmed that all of the questions were comprehensible and clear. The researcher had given out his phone number so that any doubts could be resolved immediately. This happened five times, and in all cases the outcome was satisfactory.

Control of variables

When assessing conflict management styles, complete control of all factors which could affect such styles is not possible. The characteristics of the organisational structure, for one, were not examined, nor were relationships with colleagues at the same and different hierarchical levels, the features of the various levels of authority, the models of care delivery and the opportunities for continuous professional development.

5.11.2 Recommendations

This thesis provides recommendations for practitioners, academics and researchers.

Recommendations for practitioners

Despite the limitations mentioned in the previous section, this is still considered as a valuable and important study for the nursing professional in general and the nursing profession in Arab countries and Oman in particular. The results of the present study have implications for people who work in the hospitals, whether practitioners or policy makers. Some recommendations based on the findings can be used to improve nurse managers' work environment.

- In order for the nurse managers to help staff nurses resolve conflict effectively, they first must learn how to resolve their own conflicts productively.
- The establishment of criteria for selection of nurse managers depends not only on years of experience but also on personality and management skills.
- Training programs in personal and conflict management are needed for nurse managers in Oman. These programs should be prerequisites for work as a nurse manager.
- Prior training focused on cultural factors must be given to non-national nurse managers before they arrive in Oman.
- Clear policies and job descriptions for all health workers in hospitals and for nurse managers particularly, need to be developed and implemented to reduce conflict situations in the work place.

Recommendation for academics

- Nurse managers have little knowledge of conflict management. The role of leadership is a new type of challenge in nursing that needs greater study and practice. Courses in conflict management should be available

for all nurses, and especially for the nurse managers. This should be done in two phases: firstly by introducing conflict management into undergraduate courses in the nursing curriculum, and secondly by arranging courses in professional development programs for nurse managers.

Recommendations for researchers

- Future research could establish new, standardised conflict management style instruments which would eliminate any cultural biases. The effect of these instruments would be to adequately measure differences in management styles between cultures, as nurses from different cultural regions are involved in the study.

- The cultural meanings of the five conflict management styles need to be established by research. Tests can determine whether these meanings are differently understood by people from communalist and individualist cultures, as well as by various sub cultural groups.

- Despite the fact that language posed no great problems, a translation of the instrument is recommended, with special attention given to accuracy and equivalence of the translation and the original.

- Further research is needed to explore the conflict management styles used by nurse managers in the countries whose national took part in this study, in order to find out if they use different styles when they work in their own countries.
- The current findings lay the groundwork for future research that includes the other party to the conflict and other variables.
- Such research also needs to examine the role of personality in determining conflict management styles.

- In order to avoid the limitations of self-reporting referred to above, and to verify the results, the use of triangulation with observations of real conflict behaviour should be considered.
- Future research should examine subordinates' views on the conflict management styles used by their superiors.
- This study did not consider the specific nature of conflicts for nurse managers. Future studies might wish to consider conflict with peers in an organisation, and with patients, other health workers and supervisors to obtain deeper insights into possible similarities or differences in the conflict management styles used.

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5.11.3 Conclusion

Nurse managers' work represents an environment in which conflict easily occurs and can be difficult to manage because of the different ways in which participants view it, especially when they are from different cultures and genders and have different nursing qualifications. There is a need to understand conflict management from nurse managers' perspectives. This understanding would help nurses better evaluate how to handle conflict situations. Also, understanding the nature of conflict and how people from different cultures manage it can benefit organisations in many ways. Conflict management styles that incorporate nurse managers from different culture and from both genders will help to balance the knowledge base in organisational and administrative nursing literature. Insight into the values of culture and gender could help nurses managers better understand conflict management styles using different perspectives and thereby enhance the environment of nursing organisations.

Quantitative and qualitative investigations are complementary forms of methodology in this study, and were used to explore the conflict management styles used by nurse managers in the Sultanate of Oman. The quantitative approach provided a snapshot that could apply to the larger population from which the data were collected. The qualitative data provided more in-depth and a wider range of information. They helped clarify and provide insights into issues to which quantitative analysis could not provide much direct access. A qualitative approach is especially valuable when one is studying a sensitive topic like culture. When both methods yield similar findings, conclusions and generalisations can be made with greater confidence. The body of study in the area of conflict styles and competence associated with those styles has relied mainly on quantitative methods; this mixed method study has provided the field with additional information, as well as a more comprehensive approach to gaining in-depth understanding of how nurse managers in different levels from different cultures with different qualification manage their interpersonal conflict. As a conclusion, with more years of experience, qualifications and higher level of management, styles of integrating and compromising are more used than obliging, dominating and avoiding styles

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Appendices

Appendix A: Participants' information sheet

Section A-1: Information Sheet

Dear Participant,

You are being invited to participate in a research project conducted by Zaid Al-Hamdan a doctorate student at Health and Life Sciences School at De Mont fort University in UK. The purpose of this study is to explore and describe the conflict management styles used by Nurse Managers in Sultanate of Oman, and to examine the statistical differences with respect to some demographic variables.

Participation in this study is entirely voluntary. You may refuse to participate or you may withdraw at any time by telling the researcher. You do not have to answer any question you do not want to answer.

You may not personally benefit from your participation but it may be the nursing profession in general will benefit from it.

It will take 15 minutes to complete the questionnaire.
All information reviewed and collected will be held in the strictest confidence. Your name and your hospital's name will remain confidential to assure that your job security will not be in jeopardy because of the information provided. If this research is published, no information that would identify you or your hospital will be written. Moreover, no one inside or outside of your hospital will have access to the information. Only the researcher and his supervisors will have access to the information provided in the study.
If you have any complaint regarding the study you can contact your head of nursing or to the research committee in your hospital.
If you have any question about the research and your participation, please contact Zaid Al-Hamdan at 99429822 or my local supervisor Dr Raghda Shukri 99268343 or the researcher supervisor Mrs. Jill Barr at 0044-116201 3960. If you have any question about your rights as a research participant, contact the faculty research office, De Montfort University at 0044 116 201 7118.

The ethics committee of the De Montfort University and Ministry of Health has approved the contents and use of this letter of information and accompanying informed consent form.
For any enquiry please don't hesitate to call me any time or e mail me at zaid_hamdan@ hotmail.com
Thank you for your cooperation.
Yours sincerely,
Zaid Al-Hamdan
PhD Candidate
De Montfort University

Section A- 2: Informed Consent

Please read all of the statement and put your initial in the box next to it before you sign the form

1- I have read and understood the attached letter of information, and I freely and voluntarily agree to take part in the research. ☐

2- I have been given a copy of the letter of information and will be given a copy of the signed and dated Consent Form. I have received an explanation of the purpose and duration of the research and the potential risks and benefits that I might expect. ☐

3- I was given sufficient time and opportunity to ask questions and my questions were answered to my satisfaction. ☐

4- I am aware that the conduct of this research has been reviewed and approved by the ethics committee of the Ministry of Health. ☐

5- I am free to withdraw from the research at any point of time, and for any reason. ☐

6- By signing and dating this document, I consent to participate in the research. ☐

Respondent's Signature: _____ Date: _____

Researcher's Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Section A- 3: Questionnaires instruments

Section One- General Information:

Please help me by completing the following

1. 1- **Gender:** ☐ Female ☐ Male

1.2- **Marital Status:**

☐ Single ☐ Married

☐ Divorced Others (Please specify):_____

1.3- Age: _____

1.4-***Nationality*:**

☐ Omani ☐ Indian ☐ Philipino

☐ Jordanian ☐ British ☐ South African

☐ Malaysian ☐ Tanzanian

Others (Please specify):_____

1.5 -***Formal Nursing Education*:**

☐ General Nursing Diploma ☐ Bachelor of Science in Nursing

☐ Specialized Diploma ☐ Master Degree in Nursing

Others (Please specify):_____

1.6- ***Current Post*:**

☐ Ward Incharge ☐ Hospital Supervisor ☐ Unit Head

☐ Assistant Head of Nursing ☐ Head of Nursing

Others (Please specify):_____.

1.7- Years of Experience as *Registered Nurse*: _____

1.8- Years of Experience as a *Nurse Manager*: _____

1.9- Years of Experiences in this *Current Post*: _____

Section A- 4: Invitation for the Focus Group Interviews

To satisfactorily complete this questionnaire. I intend required to perform a focus group interview which should be conducted in your hospital with 6-12 nurse managers for about 60-90 minutes. Your participation would be greatly appreciated.

If you would like to be a member in this focus group interview, simply take off this page, fill it in and return it back to the nursing office. The researcher will then call you for arrangements.

My Name: _____
My Phone number: _____

Section A-5: Conflict Management Styles instrument

Please **recall as many as recent** situations as possible when **you** have been involved in conflict in your Hospital. For such situations, indicate the extent to which **you usually** act by putting a cross (x) in the appropriate box for each question below. **(Strongly Agree, "SA" Agree "A", Neutral" N", Disagree "D", and Strongly Disagree "SD")**

No	Item	SA	A	N	D	SD
1.	. I generally try to satisfy the needs of others					
2.	. I try to carefully examine a problem with others to find a solution acceptable to both of us					
3.	I try to meet others halfway when solving a serious conflict					
4.	I try to incorporate my ideas with those of others to come up with a decision jointly.					
5.	I try to work with others to find solutions to a problem which satisfy our expectations					
6.	I use my influence to get my ideas accepted					
7.	. I try to keep my conflicts with others to myself because I want to avoid being in an embarrassing/difficult situation where I am forced to make important decisions in a short amount of time.					
8.	I usually avoid open discussion of my differences with others.					
9.	I use my authority to make a decision that gives me an advantage.					
10.	I usually follow the wishes of others.					
11.	I avoid meeting others who I am in conflict with					
12.	I exchange accurate information with others to solve a problem together.					
13.	I usually let others get what they want.					
14.	I usually propose a middle ground to end extreme Situations.					

No	Item	SA	A	N	D	SD
15.	I negotiate with others so that compromises can be reached.					
16	I try to stay away from disagreement with others					
17	I surrender to the wishes of others					
18	I use my knowledge and experience to reach decisions in my favour.					
19	I often go along with the suggestions of others.					
20	I use "give and take" so that a compromise can be made					
21	I am generally firm in defending my side on an issue.					
22	I try to bring all our concerns out in the open so that the issues can be resolved in the best possible way.					
23	I collaborate with others to create decisions acceptable to everyone involved.					
24	I try to satisfy the expectations of others					
25	I sometimes use my power to win in a competitive					
26	I try to keep my disagreements with others to myself in order to avoid bad feelings between us.					
27	I try to avoid unpleasant conversations with others.					
28	I try to work with others to develop a proper understanding of a problem.					

Please now return the questionnaire sealed to the researcher via the nursing office, using the envelope provided.

Thank you very much for taking the time to answer these questions. Your help is very much appreciated

Researcher:

Appendix B: Focus group interviews transcript

B-1 Opening for the focus group

Researcher:

Hello

My name is Zaid Al-Hamdan. I am conducting a follow-up focus group interview to the questionnaire on Conflict Management Styles Used by Nurse Managers in Sultanate of Oman.

Before we start, I would like to assure you that any data gathered in this interview will be kept strictly confidential. Other than myself, only my supervisors will have access to the interview data. While nothing you say will be divulged by the researcher with no control upon the other group but the researcher hopes that the group maintain confidentiality of the discussion. This data will be summarized and included in research reports in the form of direct quotation identifying interviewees by management level, gender and qualification background only. No interviewees will identified by name. You can decline to answer any question I ask.

If you find the focus group cause you any emotional upset you can access the counselling office in your hospital for any help.

Also for the purpose of transcription and analysis, I request your permission to audio-tape this interview. Tapes will be erased as soon as the study is completed. Tapes will not be played for any one except my supervisors, if necessary, and me. The interview should require no more than two hours of your time.

Do you have any question?

Do I have your permission to proceed and to record the interview?

Body

Please answer the following questions by using specific examples and describe the situations in as much detail as you can. Keep specific situation in mind while answering the entire questions below.

1. Can you share an experience with us in your workplace leading to a conflict situation?
2. How do you address a situation when you are confronted with conflict in your organization?
3. How did you handle the situation/ resolve the conflict.
4. In what way your conflict management styles changed/ or made effect in resolving the conflict

5. What do you feel about the relationship between conflict management and issues such as age, gender, background and education? What role does it play in managing conflict situation?

Ending

Thank you very much for your participation in the study and your time. If you are interested in seeing the results of the study, please give me your address so I can send a summary of the results to you. If, for any reason, you need to contact me, please feel free to call or e-mail at the address given in the informed consent form.

B-2 First focus group interview transcript

The first focus group (focus group A) was conducted in on 21/3/0. The focus group discussion started at 0900H and ended at 1000H. Invitation was sent to 15 members from the first level nurse managers and 9 members who attended the interview; one of them declined at the beginning and 8 continued The interview was conducted at the conference room, U shaped table

ATTENDANCE:

1- A1 Male Omani nurse manager. He has 10 years as Nurse and 3 years as nurse managers
2- A2 Male Omani nurse manager. He has 10 years as nurse and 5 years as nurse managers
3- A3 Male Omani nurse manager. He has 11 years as nurse and 6 years as nurse managers
4- A4 Male Omani nurse manager. He has 17 years as nurse and 10 years as nurse managers.
5- A5 Male Omani nurse manager he has 10 years as nurse and 4 years as nurse managers
6- A6 Female Omani nurse manager. She has 10 years as nurse 3 years as nurse managers
7- A7 Female Omani nurse manager. She has 9 year as nurse and 5 years as nurse managers
8- A8 Female Omani nurse manager 5 years as nurse and 3 month as nurse managers

One female nurse manager withdrew at the beginning of the focus group interview

The researcher started the focus group by welcoming the group and giving of the instruction to them. Since no question was asked from the participants, the interview started

Please answer the following questions by using specific examples and describe the situations in as much detail as you can. Keep specific situation in mind while answering the entire questions below.

Researcher: Can you share an experience with us in your workplace leading to a conflict situation?

A2: One of my usual conflicts, I am doing it with my doctors that some times we are getting conflict. Its positive conflict; during reading the EGG and management for the patient. This patient who coming with specific EGG changes, the doctors will read it in his own way and some time I am also read it in my own so we get different result so that we start our conflict in positive way that we are build up our decision that may I am the right or he is the right but one of us he going to convenes the other for the correct I mean reading for the EGG. This is usual happened always even though with other doctors they started some of the medication. One of the patient may be he is on a failure the doctor will start some medication for him that which from my experience I feel it is not the correct drug for the patient so we start in the conflict why and up to which the patient he will be recover and will be benefit and this is usual I mean.

Researcher: Any other idea? Any other conflict situation from any one of you?.

A5: actually usually I get conflict between my staff and this example have given what we call I support one clinic as example and I told them am going to give you off or what ever if you are doing some of this thing to improve the quality of care given to the patient. Also we like to do to other clinic among the other also that all the clinics want to give the good care

A7: from my side I have getting conflict between doctors the surgical doctors we are calling them to see one patient we call the second on call and he said to call the first on call and the first on call he will said to call our interns. All doctor they are not interest to come to see the patient but they complain from the patient. So they will be conflict between the staff and the doctor.

A8: From my experience in Adult ICU, that we are receiving most of our patient they are already intubated in the wards. But still we receive some patients that need ventilator from the wards, we received them still not intubated and according to ABG

parameter some patient they need intubation. What we note that some doctors they are not aware about the ABG parameter the normal range and that staff they have to follow the ABG report and they are going to tell to the doctor if they see the patient in need for intubation according to criteria of the ABG and this what we are facing in ICU. And another thing also our ICU admission no specific criteria for admission in ICU. Some patients who are we receiving they doesn't need ICU care and this patient most of them they need high dependency. that why some patient we receive them as emergency we shift them immediately or in the next day but we keep some cases for example we have received many cases and that cases not brain death and this patient received by ICU staff trained when the third on call come to ICU to see the patient he said this patient suppose not to be in ICU. This what we are facing at present in ICU

A1: Some time I have conflict with my top manager in the hospital regarding the communication if there is some of the communication gap. Sometimes they received some letter from the department and there is meeting to attend I get the information at the late time I mean the day before the meeting or in the same day I have to attend. Always when I ask them about this why did happened and they give me few and this is the trouble of communication gap between my department and top managers.

A3: We have conflict with the administration they are coming verbal order instead they bring written order then we have problem with the policy of the hospital in different. when they bring the written order its different from the verbal order.

Researcher: Any one would like to add anything from his experience.

A6: We are facing a conflict not in my departments only even this problem in all the wards in the hospital. The staffs are shifting frequently from the ward and this is general that they shift the experienced staff from the department without replacement or they replace them with staff with one year or the new graduate. And this will make too much different and will affect the care of the patient.

A2: I want to add something. One of fine I can say conflict between the incharge and the staff is the management I mean the cases to priorities the care which is

coming in order and how we can detected. This cause good conflict leads to improve the quality of care.

A8: I want to add regarding our ICU surgical cases we received so many neuro case and RTA that we received the patient from our accident and emergency and most of them shifted to Khoula hospital and this cases I think most of them they need early neurological intervention. Which should be done here in our hospital I think the surgeon they are aware about all the treatment should be carried like example some medication which can be given early like manitol which can be given early in A/E but this is not followed in our hospital. They have to discuss with the neuro surgeon and this will take time and this will delay the patient and effect on the physiology of the brain and some time can lead to brain death.

Researcher: Okay any one like to add any thing no body ok

A4: I am brother Ali the incharge of the general pharmacy not give us enough indent what we need in RDU and this caused problem with the patients. Until now we not get what we need.

Researcher: How do you address a situation when you are confronted with conflict in your organization?

No one answer for around one minute then the question repeated as. How you address that situation?

A4: Our problem we address found this problem when their is no indent enough and this make shortage of items for that we cant give dialysis to the patient and the patient will be in trouble also.

A2: I can address the conflict when I mean there is reputation of I mean the problem which has been raised from any focus I mean person who dealing with us I mean pharmacists, doctors, radiologist and this problem is been repeated. So that time I can address the conflict in the way because we must give solution to that problem. In my situation I mean CCU setup between the staff when the staff they trying to get more I mean to connivance any matter I mean willing or un willing the situation become more sharp little bit that time I can address there is a conflict.

A6: Actually the conflict can be address first by analysing the situation then see the outcomes of the situation what the problem seeing the problem then we can analysis the conflict.

A3: Addressing the conflict by you are trying to find from where the conflict came and addressing why and the reason why its happened then we can find the solution.

A7: By investigation the situation and also by asking other people how the conflict it is happened in the words then by through by investigate following the outcome from the situation and from the other people we can see the conflict from where come and solve the problem.

A8: Actually the conflict can be address and prevent the problem from the staff. The incharge must solved this problem. But if there is conflict from the doctors the incharge must guide them or at least to give them a comment. The incharge has the role to solve this problem and talk with them but if no response then we can raise it to the head of the department.

A5: Hamad we can address the conflict if we feel there is a breakdown or the quality of care break down so that the conflict started between all the staff.

A1: For me when I recognized problem with me I discussed the matter with the top managers and they proms me to get solution but at the same time, I find another way to get the information from the source and always I am looking for another source for the information and the communication channel.

Researcher: Any one who like to added any thing here? Any point?

Researcher: How did you handle the situation to resolve or to manage the conflict?

Researcher: Each one of you just now give one example about the conflict situation how do you handled the situation to resolve or manage the conflict

A2: I have one it was the quality of patient care conflict there is a doctor he was mismanage the patient and that lead to deteriorate the patient condition and he lead to death later on. I what I have been done I collect all data from my staff and I gone to

the medical record to collect the data. I have been ask all my staff who was on the duty that time what was going on and, then at the end I was going to head of the department with my all documents and I was give the picture what happened and he start ask and answer him and we start sharing the care the and best way and where is the mistake what is the delay it was good time and to experience the conflict and this lead to how to improve the care what I mean.

A5: I handled the conflict among all the staff then all of them can be benefit from it if you cant solve it we handle it to get benefit from the conflict.

A4: For any conflict or problem we have to gather the information from the both side to solve the problem side and to working together and trying to find the solution for the any conflict

Researcher

What happened if the conflict is not solved in the area? Is there a committee like grievance committee to solve this problem?

3 of the group answer no

A3: If we have any conflict we are addressing the reason of the conflict we are trying to work to the direct person who cause this conflict so if we can solve within that closed area I mean department we solve but in case if cant be solved because of other reason so we are highlighted to other people who can solve it also if not solve we can re highlight it to more higher authority and if also not solve we can ask for meeting with people who is related with this conflict.

A4: I am brother Ali I got one conflict from my experience it reached to higher area I mean authority with my superior are and our senior and our managers taking with us and start solve the problem between me and my superior. And finally we get the solution for that conflict.

A8: I have a conflict in my area this regarding between two of my staff nurses regarding the patient quality of patient care in this conflict I was written a report regarding this also I have observe the staff for around one month not only one week so what I observe I wrote in that report and my comments and my action plane. Then I discuss it with my head unit and we give decision that I must meet all the staff and I

got all the solution regarding the patient quality care and I show them the action what we have to practice practically in our area.

A1: Actually, I got another conflict I have address before that is the venue for my department so to resolve this conflict always when we have a meeting with the superior and the top managers of the hospital we address the problem and finally we get some many proposals but none from this proposal work out. And in order to get a solution for this problem I started getting some alternative and I start and give them the proposal not waiting for them to give proposal.

Researcher: Any one likes to added any thing? No comment

We will move to other question

Researcher: In what way your conflict management styles changed/ or made effect in resolving the conflict? You do the same conflict styles daily or change according to the problem

A5: Yes, of course, we change the conflict management styles according to the problem or according to the situation and it is really get benefit I can say a good quality of care or a good result of the conflict solving a problem.

A4: From conflict to another conflict there is different style we can change if it small we can take verbally to solve the problem if there is no change we have to change our styles we can change to writing report or writing incident that happened and highlight to your superior who are can solve this problem but if the conflict effecting patient care which affecting the patient care no need to wait to repeat it so you have to take solution or procedure for that

A6: Actually I feel the conflict management styles should be according to the situation and some time we can use more than one style to solve one conflict

A2: I mean the conflict is depend on whatever if its personal or affecting the service or effecting the patient the quality or the organization effecting in which so the style

have be on according to the situation the level of it the concern person involved. should be In that level I mean changeable according to the level.

A3: To manage what we are doing how we are managing the conflict by; first to know what is the size of conflict from where it came whether it's a big conflict a small conflict, if this related to our own department or related to other departments. So it is depending on the conflict for example if I have problem with the lab as example if it is small we can go directly to the person who caused conflict. If it is big we can go to the head of that department or incharge of that department so can always managing the conflict.

A1: My problem solving by changing according to the type of the problem and the level of the person I am dealing with or I have conflict with.

A8: Regarding the style definitely it will be change for example if the conflict is related to patient care we have to follow the evidence based practice which is updating and maintain the patient care more and more.

A7: For conflict management style in my ward what I am facing as a ward a incharge so many responsibility taking even small or little responsibility am facing I am not giving the chance to the other staff to take responsibility and this leading I will be in tension in the ward and I facing problem with my family so the styles of management I change totally now and trying to change according to my position my work I will do if it not my work I will not do I will assign other staff to do.

Researcher: Any one would like to add any thing?

If the other part causes the conflict your subordinate, supervisor or same peer level you will use the same styles of the conflict?

3 participants said different styles

A5: We will use different styles

A2: It is depend the styles that with whom I mean the conflict with whom and the person who you communicate the problem if its came from the lab and normal person.

if its high you will go to the other people so to solve the problem so the way of solving the conflict is depend on the type of the conflict and from who and how.

Researcher

Any one like to added any thing here

Ok we will move to other Q

Researcher: What do you feel about the relationship between conflict management and issues such as age, gender, background and education? What role does it play in managing conflict situation?

In other meaning like example you thing your age play role in conflict management or your gender as male or female or your experience play role in that . like example now this the conflict situation and you are a male do you think if you are the female you will behave in the same way or if the other is the same gender or different gender you will used the same conflict style with both. Another probe do you think now like example brother you have 17 years experience , do you manage the conflict now like before 10 years.

A3: I think education play role in conflict management if we say 90% of the unit head and ward incharges who work in this hospital they don't have even course in management or they don't have higher education higher than nursing diploma that effect how we solving the problem. May be the experience play role but the experiences not the only solution for the problem because some problem they need people with higher education and I feel it is needed the education can play role in conflict management

A2: From this question what do you feel about the relationship between conflict management and issues such as age, gender, background and education? yes all of this can affect male as a manager he will be more able to do more conflict gender that what I face now background yes. The experience I mean staff he will more smart or will be more confidant when he doing with conflict I mean he practice this problem or he face it before that he manage that time in this aspect but this time he will thing that aspect is not benefit for me in my conflict way will important for them

Education? Yes educated people always have good mission I mean good think and I mean even the way of talking and solving the problem it will be vary easy and they trying breakdown the conflict as soon as possible and they can get the answer or the solution vary fast.

Researcher: Sorry you mention male can do more conflict but how does gender affect the conflict in management styles.

A2: I did not pick you

Researcher

Like example there is a conflict situation in your department like the ECG example you mentioned you are as a male nurse manager the same person is a female do you think she will behave in the same way

A2: I can not say all female they cant but you know the nature of female not like male. Male always fitting but female always like to be safe from that fitting and the nature

Researcher: What happened if the female is in conflict with a male patient?

A3: I think the problem not female or male the problem the problem is culture whether your culture is making you the same as a male when you are conflicting any problem or your culture is free for example if you are going to Europe or in other countries who is not the same like our culture you will get the culture for them more easy to solve any problem with the patient if male or female but in our culture the male like role we cant make it as the same. yes she can manage as female according to her culture and according to which type the problem to whom example she is a female and she is staff nurse and the conflict was with same level of staff nurse so it will be more easy to solve the conflict more than if she is a staff and she is going to conflict or solve the problem with of the medical team person.

A4: I am brother Ali I would like to say some thing here regarding to the age there is some respect for this people and for gender I think there is some habit to the gender to the male and female she like to do in his convenes the problem or they like to say I

am the right and he is wrong this habit with the people. Background yes of course it can play role. Education who have less education he will not think easy and he will not try to understand this is the problem we can solve it we can communicate to get t some solution for that so it is different From person to other person it will be different so I think again I want to say education and experience is very important for them.

A6: Regarding the conflict and this issues yes there is a good relationship. Background and education play an important role because if you are educate you will have a good experience and you can look to the conflict in different way regarding the age there is if you senior or the age can play vary important role because if you are just start. I am like brother Ali with 17 years experience and he is older than me the they are solving the problem it will be different regarding the gender it can effect the style of the conflict but it will effect the conflict for example if you are manager you have some style if you came to the manager level you should be able to manage conflict. it will be different between male or female but I think female also they can manage the conflict .

A3: I think the personality also is very important if the person who managing the conflict has good personality and educationally is highly educated or good experience he will be more confidence able to solve conflict and not like any one who not have one of this personality education and experience.

A8: I think there is relationship between the conflict management and such issue like background and education but the education is more. Because the background the staff has the experience and the conflict reputed in his institution and so they can manage it but they cant updated but for the staff who has study and did rotation in other institution and they have different conflict also they have studed and got new management and method they can updated in their institution.

A1: I think the relationship between conflict management and theses issues have two phases one is theses parameter or theses issues in the manager or in the person who have conflict with him or with her. Age wais if the manager is young I mean young or old if he older I think he has experience in solving problem. Gender wais naturally and culturally there is relationship in conflict management or solving

problem always female in the culture is weaker than the male and the male above her. Background or experience play a vital role in managing or solving the problem or the conflict if the person have good experience and gone through many of the problems and got result of it. it help that person in solving problem. Education is vary vital in this issues if give the person the scientific way in solving the problem and he will have knowledge how to deal with conflict in the future or at the same time how to manage it.

A4: I want to added some thing actually in our country in Arab countries or in the Islamic country there is some different from other countries I want to say regarding the gender if you have problem with the female you are male and she is female I think the male will try to make it easy in that conflict problem or in any problem between male and female but if there is problem between male and male it will be more problem each one will try to show I having power also the other will say same thing but if the other party is female he will try to solve the problem he will said I will try to solve the problem take it easy don't wary. In other countries there is no gender effect such this thing if male or female both will try to fight to get solution for that and they will try the right from each other.

Researcher: Do you agree boy I mean male ? What do you think?

A3: I disagree (laughing)

A4: This is what happened here in our hospital (voice raised with stress) I not said in all the country its happened in our hospital so the matter (the talk to the group) if you are agree or not agree but this is the situation in our hospital so it will effect also in our management some times so this is the problem which we are facing.

Researcher: Female do you agree with him.

Not agree with him (All laughing)

Researcher: As female do you think you received special treatment because you are female? Like example we are a conflict situation you are female and the other is

male do you think they deal with you in this way and if you are a male the other way of dealing will be different.
(The female answer I think yes)

A4: the same way what I said now I think before Aysha said no no but now she said may be there is some different

A3: I think relationship is play role in conflict management if you are good relation with other people whom you are with conflict for example if I have bad relationship with the other department may be the small problem I try to make it big problem. But if I have good relationship with that in charge for example we can solve the problem within our unit or within our department. For example if you have one big unit and all incharges of that unit they don't have a good relationship with the head of the unit be sure most of the problem will not be solved as the problem if we have a good relationship between each other. Good relationship with other it can solve many many of the problems, even some time no need to high light even to the same level of communication it can also solve the problem.

A4: Excuse me there is no committee for solving the conflict or some thing like that here. You must fight for your right if I have problem with the director general for example and I am a small staff and he is a big staff who will take my right from him this is the example even if I have some approval or if I have so many thing that can show that I am the right and he is the wrong so they are going to delete my name from ministry of health or from the hospital (all laughing) he try to show am wrong and he is right this is an example to show I am the small and he is the big person in the hospital.

A3: I am agree with him because there is no clear role what is your right and what is there right what is your responsibility and what is his responsibility. If I know 1 2 3 is my responsibility and 1 2 3 is his responsibility I can fight for my responsibility or my right according to the responsibility and he cant jump also from his responsibility in this way we can save all the problem also we can save our right with out take their right I mean without take their right.

A1: (interfering) I disagree with you because each and every job has get their own his job description

A3: its practice

A1: Yes its practice if you don't want to practice it. It's your own problem you solve it. It is practice and every body knows it.

A2: I would like to added some thing here also why we are always talk about negative conflict why we not take about positive conflict because there is many type I mean there is positive there is negative so I think you have to think about positive conflict which I mean to give respect to the person with whom we deal, no need to raised our voice. The wards you have using must be vary professional so the matter we are dealing suppose to make it easy instead we are make it complicated that why most of the conflict not need to be sharing it with the higher authority unless its effect the quality and the patient life. Respect to that all I think no need to be negative you need to be positive.

A7: No positive conflict.

A3: I will give you one example disagree with your point but I will give you one example one I have gone for one conference in that conference I should receive a mount of money during this training. Those who came from other regions they have their right because they are practicing the role. Because there is a role to give and they respect it. I did not get my right and when I fight for my right so what the answer was you will not get any thing until you boss they will agree to give you your right. The conclusion there is no clear role and no way you should go to get your right also.

Researcher

Ok female do you like to add any thing.

Ok.

The interview finished at 10 am the researcher summarized the topics discussed. There was no comment from the participants. Then the researcher provided refreshment for them.

B3: Second focus group transcript

The second focus group conducted in hospital (B) the focus group discussion started at 0830H-0930 H on 12/06/06 in the orthopaedic conference room that Hospital. Attendance (from right of the researcher)

1- **B 1** Female Omani nurse manager she have 9 years experience as registered nurse and, two experiences as nurse in-charge.
2- **B 2** is female Omani nurse manager, she has 13 years experience as registered nurse and 5 years experience as nurse in-charge.
3- **B 3** is female Omani nurse manager. She has 9 years experience as registered nurse and 3 years experience as nurse in-charge.
4- **B 4** is female Omani nurse manager: she has 20 years experience as registered nurse and 11 years experience as nurse in-charge
5- **B 5** is female Indian nurse manager. She has 20 years experience as registered nurse and 3 experience as nurse managers.
6- **B 6** is a female Indian nurse manager with 30 years experience as registered nurse and 10 years as nurse in-charge.
7- **B 7** is a female Indian nurse manager with 18 years as registered nurse and 6 years experience as in-charge nurse
8- **B 8** is a Omani nurse manager with 8 years experience as registered nurse and 1 year experience as nurse in-charge

Sitting on circle table and all agreed to participate in the focus group. After the introduction and all of them agreed for recording, the interview started:

Please answer the following questions by using specific examples and describe the situations in as much detail as you can. Keep specific situation in mind while answering the entire questions below.

reseracher: **Can you share an experience with us in your workplace leading to a conflict situation?**

B4 : yes I think it is important to share any thing in the department not only conflict so it will be benefit to other people for that at present I attached B8 she is learning from me if . You must be very clear and transparent so we have to maintain the confidentiality when we share the experience.

Researcher: Sorry, here we concern about conflict situation

B 4: We have conflict in our department like patient and nurse conflict. We have different kind of view between patients and nurse especially. I am working in A/E in triaging when we tell our patient any thing and they don't agree with us or they got another kind of view this can lead to argument and lead to conflict. So I think it is important to share?(she used her hand and strong voice here)

Researcher: what this conflict between you and your pt?

B2 : Been accepted in the hospital. Because we are referral hospital are we prefer; the hospital policy said you must been in primary health care if you not in emergency then to be transfer but we get patient come direct here and they want to see the specialist without appointment this things lead to an argument and generate to conflict.

B5 : Some time they transfer the patient without any previous information like example … the bed is not prepared to the patient coming without informing the staff and knowing any thing about the case transferring from regions to the capital so we have conflict between our staff and interior staff.

Researcher: Ok other type of conflict other than patient nurse conflict

B1: sometimes the conflict happened between the staff when we give allocation because the staff like to be allocated in easy job and when we allocate another staff the staff they start said the in-charge like you more than me because she assign in that place only. (When she talk she put her face down and she not look to the group)

B3 : The conflict between the staff some junior they not be satisfied with the shift in-charge they like this and they do become demanding to this and that and some time it is lead to conflict between the staff and shift incharge because of the misunderstanding or because of the way of the incharge talk to the junior.

B7: when the nurses try to advocate for the patient the doctors they do not like it because of the ego problem here. The nurse they will say this is the way to the thing and the doctors will say do not teach me and will bring a lot of conflict between the nurse and the doctor. (All group here said yes that right…)

B 6: some of relative bring patients from interior and they prefer to stay with the patient and not allowing the relative to stay so for that thing some relative start fight then some Omani bring permission to stay for that we get problem.

B 4 : some time the doctor received message from interior and they not inform the shift in-charge.

B 8 : Between the staff some of them they transfer from interior. And get ego problem my be some national and expatriate staff they are here since so many years and the staff transfer her while they don't have experience in this hospital and its guided by junior staff here and they not accept.

Researcher: How do you address a situation when you are confronted with conflict in your organization?

B 4: address to whom

Researcher: how you know there is a conflict situation

B 7: usually its affect the flow of the work. So when we note the flow of work effete we recognize there is a conflict in some or other way its effect the work

B 5: if it is effect on the patients

B 4: We address the conflict between the staff when they ask for changes like example I do not like to work with this or can you change my duty so we find there is some thing there is a problem between them.

B3: if the group call for help if it is among the staff.

Researcher how you will know there is a conflict

B1 : Some times there is a complain from the staff just we take both of them and we see what is the deficit in both of them and analyse it and just make how is in the right side and who is wrong. Also it is depend on how the conflict going on and about what.

B4. some time nobody have to come to you and to till you see there is problem and it is very difficult for you to know. We realize one particular time. One girl if she is post with one particular shift in-charge she already report sick because she is trying to avoid the other partner to work with that shift in-charge. actually we try to call her not because she do so and so but because your sick leave is increasing that time she

open that because I am with this in-charge I am not comfortable for that I am trying to avoid her and try to take sick leave. So this is the way not every body will come to you and every body will report I have conflict with.

Researcher: How did you handle the situation to resolve conflict?

B4 : to handle the conflict what we talking about we put a lot of interest to listen to the girl what was the problem why she take sick leave why she did not come and let her talk about the problem we give time. We listen to her and to her complains we give her chance to find solution for herself, we encourage her to talk more and to give solution after that we not judge we listen to the other person who is involved we listen to her again we give her time to talk and we give her also we encourage her to give solution then we can work together. and the end of it we bring them together and we take all of us and we try to find the best solution for both of them and the solution was to spilt to work in different shift we put them in different shift but because of shortage of nursing some times they become work together but we encourage if any thing happened to come and complain and talk and make every thing open instead to take sick leave and this will effect in her career.

B2 : even if the conflict between the patient and nurse we listen to the patient first then we listen to the staff. Some times the patient comes from interior they don't understanding any thing and they fitting for every thing and we listening to the patient then to the staff then we find solution.

B1: to solve any problem we must listen to both side and analysis the situation then according to that try to find solution.

Saida: actually what regarding the conflict between junior and senior some of them they do not understand the senior way how she doing who she take. when listen to them we give them time and we let the junior understand how the senior talk or the way she dealing like example they don't know me how I am this type of person this but you must deal with her and see always we can find another solution and getting the proof but we make them deal with other and understand each other, if still the problem addressing try to find another solution .

B5 : we can advice the people who is involve in conflict to be professional (professionalism) and to do attitude of the profession when you are professional you

will concentrate on the patient care and not to make conflict for that I don't thing they will be a problem when you are professional. And we must take our staff to that level then no conflict will be happened.

Elyamma: if the conflict between the patients relative and the staff what we usually do we try to manage and explain each thing if they cant manage. Then we try to explain to them because we cant come over the policy of the hospital and if we cant manage we call the office of the director of the hospital or public relation officer so they will come to explain to them and give them the reason why that.

B6 : one of the junior staff she call the public relation office and she fighting with them so the public relation staff came and complain that this staff she don't have the respect. I call the staff and explain to her this is not the way to talk but she is junior and she does not know how to speak to other. And we council her and we informed her how to respect the other

B8 : since in our department we work only one shift and we cant spilt the nurses if there is problem between them to work in different shift but what I do I talk with them and I try to let them work together instead of fighting with each other

Researcher- In what way your conflict management styles changed/ or made effect in resolving the conflict

According to the situation, (three of them said together).

B4: for me I think I prefer to be a situational leadership according to what I handle I will change. If you putting the person into a risk definitely your conflict management or leadership management will definitely change according to the situation I am handling. Some are urgent and some can wait and some you can form committee and has to decide by your own because you are the only senior available there and you have to decide this is right and this is wrong, this is white and this is black according to the situation you are handling.

Researcher: regarding who is in the other part.

B4: If you put the other part in the risk you have to decide

B3: Really, it is according to the situation because each situation handling in different management we will not be dealing with all the problem in the same style. If you have problem between two staff and both of them are staff you will deal in different than if the problem between patient and staff.

B4: also we work into collaboration in the win-win the solution at the end of the day but again I will go back into the situation and say you are the loser and she is the winner. Our target is collaboration and win-win solution but there is time require from me to say no by the end of day you are wrong and she is right according to the scenario.

Researcher: what about the other part position

B4 You must work very hard to convince why am right if you have time give them evidence so they can be convinced.

B3: I think both party must be good listener, I mean they must listen carefully to each other

B1: Yes both parts must try to solve the problem and try to convince each other. And they must know who is right and who is wrong or may be both of them are right so both of them have to solve the problem.

B6: if the conflict between me and some one we have to analysis our problem where the problem initiated and then to come to conclusion and we want to be win-win but some time it so difficult if both the same authority and with the evidence we have to work. If I have some thing in written and she have some thing written we can find out what is going on and we can solve the problem.

If today you have conflict with me and you used one conflict styles in the future you will used the same style or you will change it.

B8: may be this time the conflict is different. It is depend how is the situation.

B5: yes it is depending on the situation some conflict may be you can ignore today and you cant ignore it tomorrow really it is depend on the situation or on the scenario.

Researcher: What do you feel about the relationship between conflict management and issues such as age, gender, background, and education? What role does it play in managing conflict situation?

B1: I want to give one example about knowledge and experience effect in conflict. You may face different conflict situation and you are not able to solve each and every thing then you come to conflict can be related to the previous one then it is easy for you to handle. The person with knowledge is different from the other without knowledge about the situation.

Researcher: You mean knowledge as education or an experience

B1 : an experience

Researcher Ok what about education

B4: Yes, education is play role

B7: education is giving the main guidelines. Experience some thing is very different when you deal with conflict situation because without education you cant go forward. In conflict situation, you can balance the situation and know the outcomes. But may be you have a lot of knowledge and the conflict situation can't be similar, the conflict situation is different for that experience really play vary big role when you are managing the conflict.

B4: I think you need three things to manage any kind of things including conflict we need knowledge, we need skills and we need attitude if we have the three of these any thing can be resolve, so you have the knowledge and say I have a conflict with some one who have no knowledge about any thing and never he taught and come and shout I don't really I want to wait my breath I have to keep him understand I have to drop my self to his knowledge so he or she can understand what I saying I should not share his anger because if I am share his anger then will be empty because I have the knowledge and I have the power when you have the power you control the opposite person and you can say you are wrong in this way. When you have the power you will

have definitely the attitude and the skills of handling the person who don't have any things

Researcher: Ok did your study guide you to different styles of conflict management?
Participants: Yes definitely (all of them)

B4: If you have knowledge you have power when you have power you can handle and when you have power, skills and attitude and may have knowledge and skills and may be I have bad attitude I will have cant resolve the conflict because my attitude is bad say if I have good attitude and good skills but I have no knowledge how to handle it definitely I cant handle it so you need the three thing together it is golden triangle which go together which is knowledge, skills and attitude. When you have three of theses you can really have power. And the people will listen to you and really you can attack them.

Researcher: What about your gender if it play role in conflict management?
I don't think (all of them except B3 and they start laughing)

B7: female like to fight and nurses in general.

B8: no the gender not plays role the female they have the knowledge and skills and power.

B4: Ok may be the gender at home play role. But when we have in the professional we are the same.

Researcher: did you mean in social life there is role for the gender but in the profession no role?
B8: Yes, if the other part in the conflict same gender or different gender we deal in the same way

B3: yes the gender not making a difference in solving the problem. Either if they are same or different we must give the best solution for the conflict so it is the same.
Researcher: What about the culture

B7. Yes, it is play role I am coming from India our culture is totally different and how we solve the problem is different from this part of the world. if I don't know the

culture and I am in conflict and I am trying to solve the problem it is going to be a hell so I will not put my nose if I don't know the culture so the culture play role and I must know about it and it is very important the culture we must really know.

B1. I think the culture is important and play big role. When we dealing with the patient as a female some of them they are not educated even some of them educated and they not accept any thing from females. some of them educated but they will told you I will accept explanation from female. for that we have to consider the culture when we dealing.

B4: we have to respect the culture and the people and we must let our patient understand but we need our work to be done for that we must explain to our patient yes I am a female but I am the in charge here and we must let them accepted the things from me.

B5: see here the problem especially when the patient admitted for surgery even if it's a minor surgery. The family ask to stay with the patient but we ask from them to leave one with him. And they like to see him in the same day and all the family every body will come and may be it will effect on the patient and usually they start talking even if the patient having pain and every body will come and say how are you then we do till them but they not listen to us and we explain to them some time some people they do listen and some times some they don't listen in that case they start fighting what is the problem we come to see our daughter or our son we have to solve the problem and we have to listen to them also.

Researcher: Ok did your culture play role to solve this kind of conflict?

B4: a culture can be a role to put conflict I will give you an example we have nurses from China when the patient come and the patient relative it is ok for them to laugh and touch when they communicate with him. but here it is not easy especially for the female nurse to touch even if you know it difficult for you to touch it is a cultural shock we they come we must told them this is the way to do but we didn't and they didn't know its ok this is the child and this is his father its ok to hold the shoulder and explain but do our culture accept the answer no.

Researcher; If the part is with different culture or the same culture you will use the same styles with him/her.

B4: No, we will not use the same style. let us to go back to the example of the chine's nurses they don't know our culture and that is not acceptable in this area for that we must set with them and explain to them this is our culture is they have culture shock they have to learn what is accepted what is not in this country.

B3 : if the expatriate nurse want to the patient some times the patient will say I will not accept female nurse and I want male.

B4: again it's the culture I don't want male and I want female.

B6: I don't think this things is a problem in our culture like here but when we come to Oman we must accept the culture regarding what is it and we must follow it up.

B1: I think when we have a conflict we must understand the other culture of the part if the culture play role we have to understand and we have to go that person and let them understand. If we understand the other part culture the problem will be solved. So we have to come to other part level to make him understand.

Researcher: what about the year of experience it is play role in conflict management

Participants: All of them said Yes

B5: Yes, you will be more familiar to the situation and know how to solve the conflict with experience. With experience you become better than the person who don't have experience even if he having the knowledge. For that I believe experience is play role in the conflict management. And any type of managements.

B8: Yes experience play role as example I have 9 years experience in management and B4 have twenty years she expose to different types of problem a part from me and she face problems more than me and she solve more than me so she can solve the conflict better than me.

B4: experience play role in conflict management see my mother at home she is not educated and always at the end of the day we go to here and ask her advice and solution because she have life experience we not need only educational experience and professional experience we need life experience. For that we go to our parents ask

for solutions. So experience is very important (three of them moved their heads agree with her)

B3: it is the same almost the same experience play big role in solving the conflict, in each day you have different problem the person who don't have enough experience definitely he will not be able to solve the problem which is the experience will help him to solve it.

B4: especially you do not have the management books say rule number one to do like this for that the experience is important. (all laughing here)

Researcher Do you think the age will play role.

B4: the age not necessary the more you getting older the more we getting confused (all laughing and agree with her). Age not necessary

B2: I don't think so because some of them I have example my brother and my cousin my brother older than my cousin but my cousin is mature more than my brother. Totally is different even in the professional life. (most agree with her and said yes even in professional life)

B3: Actually yesterday there was a program in UAE radio about the same thing here they ask if the age make difference if you are an older or if the older always solve the problem better than the younger every body when they are calling they say it is not necessary some time the younger people they solve the problem better than the older. (All said yes. B4 said the same idea. B6 agreed and continue)

B6: B4 talk about the golden triangle and is important to solve the problem may be the age people they do not know. They will tell you this is the policy and follow that policy. Old staff is old fashion they do not like to change. All laughing and agreed with her.

Researcher: ok now if the other partner is you colleague. Supervisor or subordinate you will use the same style

B4: I will use the same (she stress on the ward and extend her finger) I will use really the same if I take to my subordinate or supervisor or colleague. What I mean by that if I to say no I will say no, if I have to say yes I will say yes. Because if I keep say yes to my boss and no to my subordinate I am not doing my part.

B1: I agree what B4 said but may be the way how you interpret I mean how we express yes it is different no matter who is the other part the answer will be the same but may be the way is different. Because the subordinate you are the one who guide them for that the way no different but if your supervisor she is more experience and she is the supervisor you have to tell her no but in diplomatic way

(The other group laugh and said in diplomatic way).

Researcher: Remember what you take here to keep it confidential.

B4: Third focus group transcript

The third focus group conducted in on 13/06/06 from 10-11 am in the conference room of the hospital and attended by four nurse managers in the middle level position.

1- C 1: female Filipino nurse manager and she is unit nurse with 25 years experience as registered nurse, 15 as nurse manager and unit head since 6 years
2- C2 Female Omani nurse manager with 15 years experience as registered nurse and 4 years experience as unit head.
3- C3 Male Omani nurse manager. Surgical unit, 20 years experience, 12 nurse managers and 2 years in this post
4- C4 Jordanian nurse manager with 33 years experience as registered nurse , 20 years as managers and 18 years in this post.

C3 left the group for around five minutes to answer the call.

C5 attend for the introduction then they call him for disaster.

Researcher: Can you share an experience with us in your workplace leading to a conflict situation?

C1: I will give you the most recent one I need to appoint someone as the in-charge of the unit. And the person who was expecting to be appointing was not appointed. She is extremely absent. She becomes angry and it's affecting the work and the staff and like that. Actually, it is not resolve but its take a lot of intervention.

C2: For me I have trained a nurse to be acting in my absent, and I want her in the future an in-charge and after all of that she disappointed me and she don't like to be as in-charge.

C3: In my unit the most destructive conflict between the medical staff and the nursing staff in one side and the administration in the other side. All the decision comes from the administration to the consultant and for the nursing side it is come from the nursing administration to us. In the administration always, there is lack of fairness or some treatment from nursing. When we complain to the nursing office they will say to us this is come from the higher administration and we can not do any thing in which the consultant call the administration and they will change decision

and that really cause the most destructive environment and this conflict still going and not resolve.

C4: I have conflict situation wrong judgment on the wrong person already I have selected one of the staff to come up to the level of the management I trained that staff I give her all the essential requirement in fact I suggest to her to attend some courses that she need to attend. The only thing we don't have the evaluation of the official personal records later we came to know and it was like a shock to us when we discover some thing like loss of honesty and that person not treat us well. Every thing was collapse the work of two years destroys in one day.

Researcher: How do you address a situation when you are confronted with conflict in your organization?

C1: It is depend on the type of the conflict on the situation it self on the scenario. Some time if the situation start you can set and discuss the situation but some time the conflict your staff they don't know for example the one we have in this case different conflict management styles to come. In some time you need to work up different styles.

Researcher: How you know there is a conflict in your departments or in your unit.

C1: The one which I refer in the meeting and we have an objective for the meeting and if we not meet the objective completely and the people raises voices in a huge argument and always keep player and we try to bring every one back to the objective of the meeting and the people start a point thing about that which we don't actually not carry out our meeting normally we don't have meeting like this going out of control like that. Eventually if the people realize we don't get to the point and the people have appointment left and this is the only way to control the meeting and we try rationalizing with certain concern they can understand so the meeting finishes like that.

Researcher: You mean by that if you not achieve the objective of the meeting you can recognize the conflict happened.

C1: Yes, this is what I mean

C2: Yes

C2: I will refer to the condition, which I mentioned. I have conflict with the nursing officer around the hospital, when I have plane to give program the infection control link nurses. The administration approved to have one from each ward and these nurses should work morning duty because I can follow up what they are doing. But it is difficult for the nursing officer to make them morning. And they put them shift duty and no communication and it is not go according to our plan in the future and I cant meet all of them daily for more communication. So it is not go on the plan to meet our plan and objective.

C3: The conflict become from the person side once he is expected the conflict. conflict could be not seen as a conflict but it causing some destruction work for example like a group of nurses who are really good yet one nurse ask to leave to move up to another area and show that because of conflict. and this show that there is a conflict for that he ask to leave , this type of conflict really lead the staff to leave

Researcher: Leave the work or the unit

C3: Leave the unit. This type of conflict need to investigate the reason behind it lead this staff to leave if this a individual reason lead that staff to leave if its some thing from the nursing administration pressurize her to leave this type of conflict really take some time to identify the situation and come with finding and approach each player and say this right and this is wrong and bring them to the table to get some sort of argument to come over of this conflict. This is another type of conflict you can't just, leave it happened and go like this.

Researcher: Do you mean this conflict lead to burnout?

C3: It could be

C4: Of course, we can recognise there is conflict before we reach to this point. The conflict can be recognizing by certain procedures. Defined the staff how they communicate with each other, the way that they approach you connecting with action they put suggestion or you will find rejection. These are the sign of burnout or construction.

C1: Yah, yah I know what you are mean before actually we see the result as burnout we want to know the early sign and I know in one particular unit I get one

complaining and actually when this one complain she talk to a lot about all people. So this what is happened in one unit one of the girl she complain that all difficult deliveries are allocated to this nationality and we want to know why this is happing if there is a reason but in actual fact the other nationality heard these people against them when I form list of the experience of them when they come to the country it is less. Is the case then do your work so if it unfair, this e people see the justify so I am expecting some problem there.

Any thing to added

C4: We can find out by sick leave, asking to be transfer out, absent from job. ..

C3: See regarding to what we refer lat last year in August we have shortage of staff.

We have face a conflict I left with few nurse and some of them are with sick leave. The nurses work 7 nigh and get 7 nigh off and they have to be called for that they shut their GSM off because she expected at any moment may be she called. She cannot show me her face because she expected I would ask her why you put your mobile phone off when you expected me to call you. This reflects the dissatisfaction among the nurse or whatever you want to name it. The number of sick leave which I monitor in my unit is 86 days in one and half month

C1: In one and half month

C3: Yes in one and half month only in my unit

C2: This affecting the staff because they not get enough day off

Researcher:: How did you handle the situation to resolve conflict?

C2: We do counselling

C1: Depend on the situation it self if for example the case I refer where the staff not satisfy with the salary because the policy treat them differently the same ward nurse it will effect on her staff and her satisfaction and I try to sort it off. Where is ideally I have problem with a particular person usually we set and do discussion about that. if we involve few people the people concern to set and sort it out some time if it unable to solve in our level we include our supervisor the nursing administration, our senior to come and set with us to solve it.

C2: If I have problem or conflict with any nurse I will go direct to her incharge or to the concern doctor. It is depend where and with whom the conflict. Some time we do meeting together and solve the problem immediately. And I try or I should not have conflict with any body.

C3:

Regarding me the way I treat it, it is depend on he type of the conflict some of conflict it is just need to ignore it and it will solve by itself. Two senior people they not tolerate each other hate each other you cant do any thing with them.

But that conflict will effect the flow of work and patient care we have carry it in all the way I thing the communication in any conflict if … if we have two staff they don't like each other they cant work with each other. The fact must be told we can tell them either you like it or no, you have to work with each other. if you don't like take leave If you like to move you can move and if you want to write complain you can do and I will report this to the administration. I don't think its right to hide it from them because it is really happened. And if you want to move you move and we submit it to the administration. My personal role in the conflict as a middle level manager who will solve this conflict need to identify need to be bring to this nurses my role is to carry to the order the satisfaction to the higher level I can do.

C4: Our role is to solve the problem when it is happened not to wait for month to get the situation to cool down and the problem to carry on. And the solutions depend on the type of the problem and the people involve in the problem.

Researcher: In what way your conflict management styles changed/ or made effect in resolving the conflict?

C1: Yes I changed my management styles, when I come to Oman I came very very patient because I am not Arabic speaking and its important to me to really understand what is the people are really meaning, because in most of the time they are unable to say it in the English in the way they feel it, the way they come across may be different from what is really feeling. The way we have to do is different. My management styles really changed

Researcher: What about your conflict management styles?

C1: Absolutely here I used different conflict management styles some times in some situation you need to be very firm, some you need to be apologize, some time or most time you need to be very fair or democratic. Yes I think you are right and I do changed my styles from time to time depend on the situation and depend on the type of conflict

C2: It is depend on the situation

C3: It depend on the conflict if the conflict going to cause problem and stop the work or block the work you must be autocratic in that style because you can say stop do. If the conflict a little and need some thing need to investigate and some thing wait we could give the time. If some thing will not stop the work and make major fact in the work you can by lazy in the management.

C4: It is depend on the player as well. Like example, some time you have two identical situations but the people who involved is different so we have different styles. If you have two similar situations, like example I have two people I have an argument and this particular one over this particular issue and I use for this two people autocrat styles and for the other one I can explain to them because their level of understanding and their acceptance is different.

Researcher: Your conflict management styles depend on the other partner who is

C1: I think so (Jihad and Ali agree)

C3: Sure

Researcher: if you have conflict with your supervisor and conflict with your subordinate and colleague you will use the same conflict management styles for all of them.

All :

It will be changed

Researcher: How

C1: Depend on the level of understanding of that person. It is not depend the other part position like example if you are my boss I will use the democrat style and if you are my subordinate I will use the autocrat styles, no it is depend on the other part level of understanding

C2: Some time you need more explanation than the other people. May be your colleague the other nursing officer understand what you need but may be the matron will not understand what is going on in your wards and what lead to conflict for that we must explain from begging what is happing.

Researcher: You mean you deal with your supervisor in different style that your colleague

C2: I must

C3: Yes either we like this or not. In this level the culture factors interfere. Certainly I will not go to say to my matron this is the way if you like do it or leave because I will not achieve what I plan to achieve by approaching her to give me solution for the conflict. If I used this style with my matron it will not be effective and I will lose all thing instead of solve the conflict and I will create more conflict but the people who are let me say the subordinate it will different and if I talk to my colleague also I will use different. Because here the politic play part diplomacy will ply a part in it and you must come to negotiation. And the negotiation skills should be adapted when you deal with the other part. Any idea you have, you have to sell it to the other side and it must be a certain level of acceptation of your idea.

Researcher: As summery

You mean your conflict management styles depend on the situation and on the other variables and your styles will be change according to other partner in the relationship

Researcher: What do you feel about the relationship between conflict management and issues such as age, gender, background, and education? What role does it play in managing conflict situation?

C2: I think when you become more experience you will have more knowledgeable and know how to manage the department.

Researcher: You mean experience by situation or by age

C2: I think by age you can solve the problem because you will know you have the experience and you learning from your situation which is not managing well.

Whenever you growing up and becoming more up manager I think you become more senior.

C3: Actually I believe the most you are subjective to the situation the better you can manage the situation (cline agree with him and repeat the same thing) . Age is not really the factor. May be your age 50 but never you face a conflict and your management style like a person who has 15 years age you must be face the situation.

C4: Experience is more important than the age.

C2: But the age when you growing up may be think more. Because for me when I become older I start, think more about the thing.

Researcher: Even without expose to any experience or to the situation.

C2: No may be in the previous experience I not manage it well but now in the future I will know how to manage it.

C1: I think the principle with the conflict management remaining the same. Yet the age that coming to play. If involve in this conflict some one here let say two people involve in the conflict one who is very old person the one who is not update him self or any thing. And the other one is the new person. I will expend more time explain to the person who is old. The old one is really will be different from the new the new one will come with knowledge and he tough conflict management and understand different management styles. The old one defiantly he know nothing. So I think it will be change because our demand on the old one to be accepting because he don't have that knowledge you know.

Researcher: What about the role of the experience?.

C4: Experience. You can have years of experience but not learn as much. It is depend on the learner. The experience not equals to the knowledge.

Researcher: But do you think experience play role

C2: Experience it can play role but if you having the manager who not updating him self, not reading more, not going to the internet, just depending on your experience and on you knowledge it is not enough

C3: I think the experience play role. I think the more you have subjective take in you consideration we colleague together and we have senior and junior work here for years together. The junior they tough about the policy, their education has completely changed than when we have young in the health care system on the other hand this very bright well educated person have to convince some body who had not been in the school for the last 30 years. When we come to the gender although I believe ladies are more wider (the lady laughing and say thank you Ali). I don't thing the gender or I think it depend in the society where you have been. If you living in our Arab world (Oman country and the others,) lady not allowed driving a car; in some of this countries and The level of decision making here and when they analysing the situation around they make our country open. The lady they can do whatever what they want.

Researcher: Sorry, I mean what role the gender play in conflict management.

C4: I think it is depend a gain in the conflict itself. Some times some certain conflict required specific gender, now when you coming to the disaster situation mostly the men can work better in the situation. But if we come to things need more reading, more talking the women can do more. The men look to the thing as whole they not look to this piece by piece

C1: I think all factors what you said in some is play role, for example when we talk about sex. You know always it will be a different the people they will highlight the differences according to the relation ship. We know in conflict management you look to her and you know she is a female and you are the male you should carry more **than** the female. For example if male and female working in the ward and female don't want to carry the patient from the wall chair to the bed and they are a fight, they will come to you and you will tell him you are the male, for this situation the sex will play apart.

C4: If you have conflict, situation, the other part male, and the same conflict situation but the part female you will use the same conflict management styles.

C1: The styles the will be the same

Researcher: Does you gender play role

C1: If my manager a male oh it is, depend on the individual, because I not work with male.

C4: Depend on the person

C2: Cline work in the maternity unit and the male can't go to delivery suit.

Researcher Sorry I not talk about delivery suitcase, I mean in general

All said

Participants: The same no change if male or female

Researcher: What about the culture

C1: Culture defiantly will play role. For example for the privacy for the female even if the male he is the doctor and he come to examined the patient he cant comfortably come and examine the patient without female staff but if I am a male in South Africa I see nothing wrong to examine the female patient; in this situation the culture effect. I came from the culture were the doctor he can go and examine the patient but here is not allowed. I feel nothing wrong with that but here absolutely no.

Researcher: Sorry. Do you think your culture play role in conflict management?

C4: You must be accepted if you like to be a manager in different culture. The culture is adapted in your management. You can not bring your culture with your management styles and like that

C2: The culture play role in our culture we have to respect every individual without effecting and compromising the patient care.

C3: We cannot ignore the culture interfere in this subject. You have management styles and we have management knowledge and in certain level we try to make as the best as we could. We can not ignore the culture (all of them say yes). For example I am a male manager and I want to sit with one of female manager I can not set with her in a vary closed area or if the door lock.

Researcher: Ok but how the culture effect in your decision.

C3: The culture effect on my on the way I deal with the people like example cline from South Africa she is different from here. In our culture you must respect your father, your senior, any body older, do not speak if any body speaking, female don't interfere with male part. The western culture in general gives some sort of freedom practice from the day birth to death. They give you the right to speak without put in consideration the person in front of you if he older than you, my father, my mother.

And of course that will affect my decision making. Like example if I meet with our director general beside his authority as director general I must respect his age, certain things I cant say to him not because he is a director general, no but because he is at a age of my father.

Researcher: You mean your culture teach you to respect the age.

C3: Exactly

C4: In our culture, you must respect the person who is older than you are even if they are wrong and some time this effect in our decision and affect the work.

C1: Our culture is different.

Researcher: How

C1: We can say what we want say if we say it in the right way. Even if we tough a lot. Like example the men her can't touch the female. If I work with my colleague and I want to greet him I can't touch him or shake hand. For that when you move from culture to different culture it is need from you a lot of adjustment and you should learn about this the new culture.

Researcher : Ok you said to respect the age and not to talk even if he is wrong.

C4: I not said my decision will be change if I am right and he is wrong No but the way how to say that and when is much much different from if he is in my age or younger than me.

Researcher: What about the education level.

C1: The education level is not necessary it is depend on how effective the person in what ever the style he used is and how he across the people. May be I have my master but for the conflict management it is depend on the style I am using. May be I am democratic but the way I use the management styles is not acceptable. To me is depend on who is receiving and if the end result is achieved. For me I work to the end result and all of us work for the specific end result in conflict situation.

Researcher: But did your education level play role in conflict management?.

C1: It could be because the theory is very important as well

Researcher: But just now you say it is not necessary

C1: If I know the theory and I am not able to practice. It not just the master if I have just the ordinary diploma and be aware about the management styles but do you know some time no need to be aware about management styles, it is just a name.

Researcher: But do you think the education will guide you to the different conflict management styles you can use?

C1: I think it would, would, absolutely yes

C4: Experience and education play very important role in conflict management

C3: Education is play role either to the negative or positive. The education will give you the tools how to attack the conflict but how you are going to use the tools the education will show you but will not show you the personality that should lead to utilize the tool because you could know the tools and to the use extremely the tool probably then you come to apply it and you will say if I use it I will effectively I will be a master for the type of person who is unsatisfied. Then I used the tool kept down this people and make them unhappy.

Researcher: Ok. You mean the education will guide you to the new way of conflict management and it's depending on you to use it positive or negative.

C3: Yes education will show you all the tools required but no way can you guarantee that tool will be effective

C2: I think education play a positive role.

C1: It play positive role

C4: When you have a theoretical background, you will have options.

C2: Yes, because you have the experience you have the practice then you need for the knowledge

Researcher Gender

Participants: There is a role for the gender

C3: I think the gender play a role in that, gender and culture are really play role in this. There is a nursing education at a moment and if will continue our focus on them there a education at a moment which is ok. But nursing curriculum need to be update to feed our need. We need all nurses to focus on conflict management rather than what is happened 20 years ago.

Researcher: You mean we need to update our curriculum to introduce conflict management to our student.

As summary, we need to update our curriculum to introduce conflict management since the conflict present with us daily.

Researcher: Any thing to added

C4: I think the nurses need to tough more about conflict management. In my opinion the conflict living with us and we don't know how to handle it. and the nurses need to understand to accept what my senior said no matter how they spoken too they must accepted and really I think they need tough in the manner not to said aggression with aggression but to be able to say what.

C3: In addition to that the rules and regulation should be change to prevent manager abuse the staff and to respect the individual. At present you can abuse the staff depend on who you are and she can not stop you and till you I will not accept this from you where she will go from their. They must be some sort of solution. I am a senior person I know that I could end up in jail and that policy and law you have to respect and you have the protection.

Researcher: Ok, we discuses about conflict in work about task conflict, communication is important in the conflict and you conflict management styles change according to situation it self. There is role for gender; there is role for age, the culture, education, and years of experience. You mention about sign of conflict like increase number of sick leave and the staff not talk with each other, not complete objective of the meeting.

C2: We can see all of this will affect the patient care.

Researcher: Any thing to add

Participants: Nothing

Appendix C : Summary of the focus group themes for each question

C1 : List of statement emerge from the participants answering the first question, can you share an experience with us in your workplace leading to a conflict situation?

Hospital A	Hospital B	Hospital C
- Usual conflicts, I am doing it with my doctors. *- Conflict between my staff.* *- Getting conflict between doctors.* *- Conflict between the staff and the doctor.* *- Some doctors they are not aware about the arterial blood gases parameter the normal range.* *- No specific criteria for admission in ICU.* *- Conflict with my top manager in the hospital regarding the communication.* *- Conflict with the administration they are coming verbal order instead they bring written order.* *- With the policy of the hospital in different.* *- The staffs are shifting frequently from the ward.* *- Shift the experienced*	*- You must be very clear and transparent.* *- Patient and nurse conflict.* *- When we tell our patient anything and they don't agree with us or they got another kind of view this can lead to argument and lead to conflict.* *- Patients want to see the specialist without appointment this things lead to an argument and generate to conflict.* *- Transfer the patient without any previous information.* *- Conflict between our staff and interior staff.* *- Sometimes the conflict happened between the staff when we give allocation because the staffs like to be allocated in easy job and when we allocate another staff.* *- The conflict between the staff.* *- Not be satisfied with the shift in charge.* *- Misunderstanding or because of the way of the in*	- Person who was expecting to be appointing was not appointed. - Disappointed me and she don't like to be as in charge. - Conflict between the medical staff and the nursing staff in one side and the administration in the other side. - Administration -always there is lack of fairness or some treatment from nursing. - Wrong judgment on the wrong person.

staff from the department without replacement. *- Conflict between the in charge and the staff is the management - I mean the cases to prioritise the care.* *- They need early neurological intervention, which should be done here in our hospital.* *- General pharmacy not give us enough indent*	*charge talk to the junior.* *- When the nurses try to advocate for the patient the doctors they don't like.* *- Conflict between the nurse and the doctor.* *- Omani bring permission to stay for that we get problem.* *- The doctor received message from interior and they not inform the shift in charge.* *- Between the staff.* *- Do not understand the senior way.*	

C2 : List of statement emerge from the participants answering the second question. How do you address a situation when you are confronted with conflict in your organization?

Hospital A	Hospital B	Hospital C
- *Make shortage of items for that we cannot give dialysis to the patient and the patient will be in trouble.* - *This problem is been repeated.* - *Analysing the situation.* - *Trying to find from where the conflict came and addressing why and the reason why it's happened.* - *By investigation the situation.* - *By asking other people how the conflict it is happened.* - *Raise it to the head of the department* - *If we feel, there is a breakdown or the quality of care.* - *Discussed the matter with the top*	- *It's affect the flow of the work.* - *If it is effect on the patients.* - *We address the conflict between the staff when they ask for changes.* - *If the group call for help if it is among the staff.* - *Complain from the staff.* - *Report sick because she is trying to avoid the other partner to work with that shift in-charge.*	- *Depend on the type of the conflict on the situation.* - *Start you can set and discuss the situation.* - *People raises voices in a huge argument.* - *Don't actually not carry out our meeting normally.* - *You not achieve the objective.* - *No communication.* - *Causing some destruction work.* - *Ask to leave to move up to another area.* - *Staff to leave.* - *conflict lead to burnout.* - *They communicate with each other.* - *Complaining.* - *Sick leave.* - *Ssking to be transfer out.* - *Sbsent from job.*

managers.		- *they shut their GSM off.* - *Dissatisfaction among the nurse.* - *Affecting the staff*

C3 : List of statement emerge from the participants answering the third question. How did you handle the situation to resolve or manage the conflict?

Hospital A	Hospital B	Hospital C
- *I was going to head of the department with my all documents and I was give the picture what happened and he start ask and answer him and we start sharing the care* - *If you can't solve it we handle it to get benefit from the conflict* - *Solve the problem* - *Are trying to work to the direct person who cause this conflict so if we can solve within that closed area I mean department we solve*	- *Listen to the girl what was the problem* - *We give her chance to find solution for herself, we encourage her to talk* - *Also we encourage her to give solution then we can work together* - *Try to find the best solution* - *We listen to the patient first then we listen to the staff* - *Must listen to both side* - *When listen to them we give them time and we let the junior understand*	- *Do counselling* - *Depend on the situation* - *Usually we set and do discussion about that* - *Unable to solve in our level we include our supervisor the nursing administration* - *I will go direct to her in-charge or to the concern doctor* - *Meeting together and solve the problem immediately* - *I try or I should not have conflict with anybody* - *It is depend on he type of the conflict*

- *Highlighted to other people who can solve* - *Our managers taking with us and start solve the problem* - *Was written a report regarding* - *I must meet all the staff and I got all the solution regarding the patient quality care* - *Address the problem and finally we get some many proposals* - *I started getting some alternative*	*how the senior talk or the way she dealing. If still the problem addressing try to find another solution* - *Advise the people who is involve in conflict to be professional (professionalism)* - *Explain each thing if they can't manage* - *Explain to them because we can't come over the policy of the hospital* - *We call the office of the director of the hospital* - *Complain that this staff she don't have the respect* - *I try to let them work together instead of fighting with each other* - *Some you can form committee* - *There is time*	- *Some of conflict it is just need to ignore it* - *Communication in any conflict* - *The fact must be told we can told them either you like it or no you have to work with each other* - *If you like to move you can move* - *If you want to write complain you can do and I will report this to the administration* - *My role is to carry to the order the satisfaction to the higher level I can do* - *Role is to solve the problem when it is happened* - *The solutions depend on the type of the problem and the people involve in the problem* - *You need to be very firm*

	require from me to say no	- *Need to be apologise* - *Block the work you must be autocratic in that style*

C4 : List of statement emerge from the participants answering four question. In what way were your conflict management styles changed or made effective as a result of the conflict's management?

Hospital A	Hospital B	Hospital C
- *We change the conflict management styles according to the problem or according to the situation* - *From conflict to another conflict there is different style we can change* - *Conflict management styles should be according to the situation* - *Depend on whatever if its personal or affecting the services* - *The style has been on according to the*	- *According to the situation* - *I prefer to be a situational leadership* - *It is according to the situation because each situation handling in different management* - *We work into collaboration in the win-win the solution* - *You must work very hard to convince why am right* - *We have to analysis our problem where the problem initiated* - *We want to be win-win*	- *Yes I changed my management styles* - *Here I used different conflict management styles* - *Some situation you need to be very firm, some you need to be apologise* - *Depend on the situation* - *It depend on the conflict* - *It is depend on the player as well* - *Depend on the other partner* - *Depend on the level of understanding of that person* - *If you are my boss, I will use the*

situation the level of it the concern person involved - *So it is depend on the conflict* - *According to the type of the problem and the level of the person, I am dealing with* - *Regarding the style definitely it will be change* - *Change according to my position my work* - *We will use different styles* - *Depend the styles that with whom I mean the conflict with whom* - *Depend on the type of the conflict and from who and how*	- *It is depend how the situation is*	*democrat style* - *If you are my subordinate, I will use the autocrat styles* - *You deal with your supervisor in different style that your colleague* - *In this level the culture factors interfere* - *I will not go to say to my matron this is the way if you like do it* - *Politic play part*

C5 : List of statement emerge from the participants answering question five. What do you feel about the relationship between conflict management and issues such as age, gender, background and education? What role does it play in managing the conflict situation?

Hospital A	Hospital B	Hospital C
- *I think education play role in conflict management* - *May be the experience play role* - *Male as a manager he will be more able to do more conflict* - *Educated people always have good mission I mean good think* - *Educated people can get the answer or the solution vary fast* - *The nature of female not like male* - *Female always like to be safe from that fitting and the nature* - *Problem is culture whether your culture is making you the same as a male*	- *Knowledge and experience* - *Education is give the main guidelines* - *When you deal with conflict situation because without education you can't go forward* - *Experience really play vary big role when you are managing the conflict* - *We need knowledge, we need skills and we need attitude* - *If you have knowledge you have power* - *Need the three thing together* - *Gender not play role in conflict management* - *May be the gender at home play role* - *If the other part in*	- *When you become more experience you will have more knowledgeable and know how to manage the department* - *I think by age you can solve the problem* - *Age is not really the factor. May be your age 50 but never you face a conflict and your management style like a person who has 15 years age* - *Experience is more important than the age* - *The age that coming to play* - *You can have years of experience but not learn as much* - *The experience not equals to the knowledge* - *I think the*

- *Conflict with the same level is easy to solve rather than if the doctor involved* - *Regarding to the age there is some respect for this people and for gender* - *Background yes of course it can play role* - *Education who have less education he will not think easy and he will not try to understand* - *Education and experience is very important for them* - *Background and education play an important role* - *Age can play vary important role* - *Gender it can effect the style of the conflict* - *The personality also is very important*	*the conflict same gender or different gender we deal in the same way* - *Culture play role* - *We have to respect the culture* - *Culture can be a role to put conflict* - *It's the culture I don't want male and I want female* - *With experience you become better than the person who don't have experience even if he having the knowledge* - *The age not necessary the more you getting older the more we getting confused* - *Old staff is old fashion they don't like to change*	*experience play role* - *I don't thing the gender or I think it depend in the society where you have been* - *Some times some certain conflict required specific gender* - *She is a female and you are the male* - *The same no change if male or female* - *Culture defiantly will play role* - *We can't ignore the culture interfere in this subject* - *The culture effect on my on the way I deal with the people* - *In our culture you must respect your father, your senior, any body older, don't speak if any body speaking, female don't*

- *There is relationship between the conflict management and such issue like background and education but the education is more* - *Age was if the manager is young I mean young or old if he older I think he has experience in solving problem.* - *Gender wais naturally and culturally there is relationship in conflict management or solving problem always female in the culture is weaker than the male and the male above her* - *Background or experience play a vital role* - *Education is very vital in this issues.* - *Country in Arab*		*interfere with male part* - *The western culture in general give some sort of freedom practice* - *Like example if I meet with our director general beside his authority as director general I must respect his age* - *Even if they are wrong and some time this effect in our decision and effect the work* - *education level is not necessary (she changed her mind later)* - *Theory is very important* - *Experience and education play very important role in conflict management* - *Education play a positive role* - *There is a role for the gender*

countries or in the Islamic country there is some different from other countries - *Is play role in conflict management*		- *We need to update our curriculum to introduce conflict management to our student.* - *I think the nurses need to tough more about conflict management.* - *Rules and regulation should be change to prevent manager abuse the staff and to respect the individual*

Appendix D 1 Ethical approval from MOH Oman

Sultanate of Oman
Ministry of Health
Directorate General of Health Affairs
Department of Non-Communicable Diseases Surveillance & Control

سلطنة عُمان
وزارة الصحة
المديرية العامة للشؤون الصحية
دائرة مراقبة ومكافحة الأمراض غير المعدية

Appendix D: Ethical approval

Ref. : MH/DGHA/DNCD/R&S/219/05

Date : June 26, 2005

الرقـــم :
التاريخ :
الموافق :

Dr. Zaid Mohammed Issa Al-Hamdan
Nizwa Hospital
Post Box 1222, PC 611 Nizwa
Dakhiliya Region

After Compliments,

Re : "Conflict Management Styles used by Nurse Managers in Sultanate of Oman"

With reference to the above study, I am pleased to inform you that, your study plan was sent to H.E. The Undersecretary for Health Affairs and Chairman of the Research & Clinical Studies Committee. He has no objection to the study and it is ethically approved on the understanding that you will be fully abide by the submitted protocol.

On behalf of the chairman and committee members I wish you all the best.

Thanking you and with kind regards,

Jawad Al-Lawati.

Sultanate of Oman Ministry of Health Directorate General of Health Affairs

Dr. Jawad Al-Lawati
Rapporteur of Research & Clinical Studies Committee

Cc : Director, Office of H.E. The Undersecretary for Health Affairs
Director General of Health Affairs
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هاتف : ٦٩٦١٨٧ (٩٦٨) – فاكس : ٦٩٥٤٨٠ (٩٦٨)

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Dean: Prof Gillian Grant BA PhD CertEd (FE)

16 September 2005

Appendix D2 Ethical approval from DMU

Mr Zaid Al-Haman
P.O. Box 1222
Nizwa Hospital
Nizwa 611
Sultanate of Oman

Dear Mr Al-Haman

Re: Ethical Approval Application for *'Conflict Management Styles used by Nurse Managers in Sultanate of Oman'*

I am writing regarding your application for ethical approval for a research project titled to the above project. This project has been reviewed in accordance with the Operational Procedures for De Montfort University Faculty of Health and Life Sciences Research Ethics Committee. These procedures are available from the Faculty Research and Commercial Office upon your request.

I am pleased to inform you that ethical approval has been granted by Chair's Action for your application '*Conflict Management Styles used by Nurse Managers in Sultanate of Oman'*. This will be reported at the next Faculty Research Committee, which is being held on Wednesday 22nd September 2005.

Should there be any amendments to the research methods or persons involved with this project you must notify the Chair of the Faculty Research Ethics Committee immediately in writing. Serious or adverse events related to the conduct of the study need to be reported immediately to your Supervisor and the Chair of this Committee. Also, The Faculty Research Ethics Committee should be notified by e-mail to HLSFRO@dmu.ac.uk when your research project has been completed.

Yours sincerely,

Professor Paul Whiting
Chair
Faculty of Health and Life Sciences
Research Ethics Committee

cc: *Prof D Anthony*
file